Exploring the early workings of emerging Clinical Commissioning Groups: Final report

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List of abbreviations

A&E	Accident and Emergency
APMS	Alternative Provider Medical Services
AO	Accountable Officer
CCG	Clinical Commissioning Group
CFO	Chief Financial Officer
CoM	Council of Members
COO	Chief Operating Officer
CQC	Care Quality Commission
CSS	Commissioning Support Service
DH	Department of Health
GB	Governing Body
GMS	General Medical Services
GPCC	GP Commissioning Consortia
H&WB	Health and Wellbeing Board
LA	Local Authority
NHS	National Health Service
NHSCB	NHS Commissioning Board
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PEC	Professional Executive Committee
PH	Public Health
PMS	Personal Medical Services
PPI	Patient and Public Involvement
QIPP	Quality, Innovation, Productivity and Prevention
SHA	Strategic Health Authority

Executive summary

Introduction

This report presents the findings from a study of developing Clinical Commissioning Groups (CCGs) in England. The aim of the study was to explore the early experiences of emerging Clinical Commissioning Groups as they set themselves up as 'Pathfinders' and moved towards authorisation, investigating the factors that had affected their development and drawing out lessons for the future. The specific research questions addressed in this report are:

- What have been the experiences of Pathfinder CCGs over the past year?
- What factors have affected their progress and development?
- What approaches have they taken to:
    - Being a membership organisation?
    - Developing external relationships?
    - Commissioning and contracting?
- What lessons can be learned for their future development and support needs?

Background

The Pathfinder programme was set up to enable aspirant CCGs to move forward under existing legislation. The programme was announced in October 2010 and the first Pathfinders were established in January 2011. There were five waves of Pathfinders, and by the end of this process virtually the whole of England was covered by an emerging CCG. At the start of this research there were 259 Pathfinder CCGs; at the end of the research period there were 212 emerging CCGs moving towards authorisation. This executive summary presents the key findings of a study covering the time up to the first applications for authorisation. The first section of the results is structured chronologically, highlighting the issues that arose and were important as the CCGs developed. This is followed by a summary of the factors that were found to affect progress and development. A third section provides more detail relating to the experiences of being part of the Pathfinder programme. The final three sections of the results present the findings relating to those issues which were less time-dependent, drawing out thematically the evidence that we found. The final section of this Executive summary draws together some of the key lessons arising from the research.

Disclaimer: at the time this research was carried out, CCGs were officially sub-committees of their local PCT Cluster. Technically they should be referred to as 'emerging CCGs' as CCGs will not officially exist until after they have been authorised. However, actors on the ground routinely refer to themselves as a CCG. In this report, therefore, where the term CCG is used, this refers to emerging CCGs which are awaiting authorisation.

Methods

The overall study design involved detailed qualitative case studies in eight CCGs, along with national web surveys at two points in time and telephone interviews with a random sample of CCGs. Data were collected between Sept 2011 and May/June 2012. Qualitative data collection included: interviews with a wide variety of GPs and managers (96 in total); observation in meetings (146 meetings, 439 hours); and study of available documents. The web surveys were carried out in December and April/May. Response rates were 41% and 56% respectively. A total of 38 telephone interviews were carried out (response rate 38%). As a result of significant delays in obtaining the information needed to carry these out, telephone interviews are ongoing at the time of writing this report. All data sources (apart from telephone interviews) were analysed together, and the results presented here represent a synthesis of the case studies with the national-level data.

The strength of this approach has been the quantity and depth of the data collected. The case studies have provided a detailed picture of CCG development, whilst the web surveys have provided descriptive data which has set these findings in a national context. This triangulation of data sources provides confidence that our findings are relevant to the wider population of CCGs. The main weakness of the approach has been in the speed with which the research was carried out, limiting the time available for reflection. Change was constant throughout the research, and the picture provided must be viewed as a snapshot of a developing situation. In addition, the data obtained from telephone interviews was incomplete at the time of writing this report, and aspects of this data have therefore only been included where they provide additional context.

Results

Overall, we found evidence of a great deal of activity and hard work on the ground by those involved with the development of CCGs. Governing body GPs and local managers are working together with a great deal of energy and commitment to implement the changes.

The journey so far: Pathfinder experiences from inception to applying for authorisation

CCGs have undergone a great deal of change and development since the inception of the Pathfinder programme. We found that:

- Survey responses suggest that most CCGs initially set themselves up in ways which reflected previous administrative groupings, some dating back some time, including, for example, the recreation of Primary Care Group boundaries
- Early Pathfinder applicants (from both case studies and survey) told us that they believed that they would derive some benefit from being 'early adopters', but felt that this had been lost once the programme was extended
- The *Strategic Health Authority (SHA) led risk assessment* process was a potent driver of activity in case study sites. As part of this, some groups felt themselves to be pushed towards mergers which were initially unwelcome, and which were experienced as a hindrance to development.
- *Structures and governance* remain areas in which rapid and ongoing development is occurring. Structures adopted so far are complicated and multi-layered, and it remains unclear how CCGs in the case study sites will address the need to be accountable both upwards to the NHS Commissioning Board (NHSCB) and downwards to their members and to the public at large. Our research suggests that there are a number of significant outstanding issues relating to CCG structures that need to be addressed:
    - What is the relationship between the 'assurance' level and the 'operational' level within CCGs (see section 3.1.4), and are both groups clear as to their responsibilities?
    - What is the relationship between the 'assurance' level and the wider GP membership?
    - Who is responsible for setting the overall strategy and forward plans of the CCG?
    - What is devolved to what level within the organisation, and who can make decisions about which issues?
    - How much overlap in activity and responsibilities is there between the different organisational levels?
- Whilst case study CCGs are aware of the issue of *conflicts of interest*, it remains unclear how these will be addressed
- *CCG governing bodies* were developing and changing throughout the research period in response to changing guidance. Particular issues which arose in both the case studies and surveys include: the difficulty of bringing in new GP leaders (with only

one out of eight case study sites achieving this); the requirements to appoint a nurse and a hospital consultant, which were not welcomed by the majority of case study sites; the gender balance of CCG Governing Bodies, with most dominated by male GPs; and little representation from other clinical groups such as Allied Health Professionals or Pharmacists

- The movement of *Commissioning Support* from the Primary Care Trust (PCT) Cluster into a new, standalone organisation has been experienced as difficult by most of our case study CCGs, as they have been asked to sign initial agreements with organisations which are not yet fully formed and about whose capabilities they are unsure. Emerging CCGs are anxious to retain both trusted staff and a local focus. This transition process has caused considerable disruption for both emerging CCGs and the managers working with them
- Most CCGs responding to the survey have nominated a preferred *Accountable Officer* and a *Chair.* In the case studies we found little appetite for open recruitment for these posts, with CCGs preferring to appoint those currently working with them to the senior posts. Guidance on this issue was found by some in the case study sites to be confusing, and the late issuing of the Human Resources guidance relating to staff appointments (in May 2012) was felt to have been a problem by all the case study sites
- Preparing for the *authorisation process* was acknowledged by case study sites to be very labour and time intensive, with some expressing concern that this had distracted from the 'real work' of commissioning. The interactive self-assessment tool was generally felt to have been useful, and support from PCT Clusters and SHA Clusters was valued highly.

Factors affecting progress and development

Whilst our case study CCGs were quite different across a range of characteristics, we found some common factors affecting their development:

- The calibre and personalities of the *leading individuals* within the CCGs (both GPs and managers) had a significant impact on the way that the CCG developed in each area
- *History* was important, in terms of both individual and institutional histories. All of the GPs who initially adopted the main leadership position in each case study site (either as Chair or AO) had been in a local leadership role in the past. Historical relationships are regarded as an important strength, and have an impact on how the current task is perceived and approached.
- *PCT Clusters* have been managing a difficult situation between 'letting go' to enable CCG development whilst maintaining control of the system. At best, this relationship has been extremely supportive and helpful, but in other areas there have been frustrations, with CCGs complaining that their local PCT Cluster was trying to be too controlling. Trust and good interpersonal relationships have been the key enablers of supportive interactions
- The degree of closeness in relationships between case study CCGs and their local *SHA Cluster* have varied Some SHA Clusters issued detailed guidance which was not always consistent with the messages from the DH as a whole, but regional workshops and meetings were felt to be particularly helpful
- As might be expected, *locally specific factors* had a significant impact on how CCGs developed and approached their task. Some of these factors are time limited – for example, the fall out from mergers is likely to settle over time. However, others, such as struggling local Trusts and crossing Local Authority (LA) boundaries are issues that will continue to impact upon these CCGs over time
- The national *political context* (including, for example the legislative 'pause') has affected the development of CCGs. In general, our case study CCGs do not wish to

be seen either as ‘supporters’ or ‘opponents’ of the national policy; rather, they see themselves as working to improve care for patients regardless of the national policy situation in which they are operating. There is widespread support for the idea of greater clinical involvement in commissioning. However, many believe that this could have been achieved without the need for the current national reorganisation

Pathfinder experiences: overall assessment of the Pathfinder approach

Findings from the case studies and surveys suggest that:

- The Pathfinder process was a very effective way of generating momentum and achieving sign up for the development of CCGs. Participants generally regarded becoming a Pathfinder as a ‘badge’ that they needed to achieve in order to gain credibility and to begin their development
- In terms of practical support, national and regional meetings were regarded as helpful, especially those at which national leaders were present. Other aspects of the Pathfinder programme (eg online forum) were not prominent in our case study sites, and were not mentioned by survey respondents
- Opportunities to network with peers were valued
- In general, the early promise that Pathfinder CCGs would be able to influence the overall direction of the policy was not felt to have been fulfilled. There was a perceived disconnect between early encouragement to develop their own ways of doing things and an emerging sense that there was an official agenda which must be adhered to
- Evidence from both case studies and surveys suggest that the lack of clear guidance (especially in the early stages) has been a particularly problematic issue for many groups
- Individuals in leadership positions have found the process to be challenging but personally rewarding
- There is a clear appetite amongst CCGs for the NHS Commissioning Board to avoid being too directive to CCGs, allowing them to develop and to respond to local needs with a minimum of central directives

Approaches to being a membership organisation

Findings from case studies and surveys suggest that CCGs are still working out what it means to be a membership organisation.

- From the case studies, some smaller CCGs are working hard to ensure that their organisations are perceived as being ‘owned’ by their members. In larger CCGs we did not see this
- Communication with the membership is seen as important by all case study CCGs. We identified three different approaches to communication:
    - as predominantly a one way process, focused upon ‘informing’ the membership
    - as a limited two way process, with the emphasis upon both informing the membership and capturing ‘usable intelligence’ from the clinical front line
    - as a full two way process, focused upon capturing the views of the membership to set the direction of the group as well as on keeping them informed
- The role, purpose and remit of Locality groups (within CCGs) remains unclear, especially in those groups which have merged. In particular, there is lack of clarity over the extent to which Locality groups should have responsibility for budgets and for commissioning decisions. This was found in the case study sites and is backed up by the findings of the telephone interviews
- Case study CCGs and survey respondents regard the performance management of practice behaviour relating to commissioning such as referrals and prescribing is regarded as a legitimate role for CCGs, and this builds upon work that was already

underway in all sites. There is a potential tension between the desire to be a meaningful membership organisation and the perceived need to manage performance.

Approaches to the development of external relationships

CCGs are aware of the importance of their external relationships. From the case studies and surveys we found that:

- The comprehensive nature of the current reorganisation has generated concerns about disruption to existing partnership working with external organisations
- Most legacy PCTs had well developed systems for working with their Local Authorities (LA), and there is a general recognition that closer integration between health and social care will be vital if current services are to be maintained. Some case study sites report improved relationships with their LA since beginning their CCG journey, and are keen to develop even closer relationships by, for example, co-locating or sharing comnmissioning support staff. However, there is some lack of clarity about the rules relating to this.
- Health and Well Being Boards (H&WB) are in different stages of development across our case study sites. Joint development sessions between CCGS and H&WB are valuable, but there are still some uncertainties about how CCGs and H&WBs will work together in future. In particular, the following issues arose:
    - The exact demarcation of responsibilities
    - Maintaining a local focus in those areas with a two tier LA
    - Different ways of working between CCGs and Local Authorities
    - The number of meetings GP members on H&WBs will be required to attend
    - The impact of politics, particularly if a Council changes hands
    - The lack of formal powers for either CCGs or H&WBs to influence each other's work
- There are widespread concerns expressed in both case studies and surveys as to how Public Health will function in the new system
- Patient and public involvement (PPI) is something to which all of our case study sites were committed. However, they continue to wrestle with familiar issues, such as who is a valid 'representative', and in which aspects of the commissioning process can PPI be most effective/have legitimacy. Current approaches appear to build upon existing approaches developed by PCTs.
- The development of National and Local Healthwatch is proving slow in many areas
- All of our case study sites recognise the importance of working with their neighbouring CCGs, with both formal and informal collaborations under development. It is not yet entirely clear how sharing personnel between different statutory bodies will work in practice, in particular we found differing opinions as to whether shared posts would also allow sharing of other statutory functions such as audit
- Case study developing CCGs are clear that engaging productively with their local providers will be vital. There are some concerns about managerial dominance of providers and the strength of large Foundation Trusts
- Some other existing local partnerships have been disrupted by the change, and case study participants were unclear how, for example, some local actors such as Community Pharmacists will contribute in the future
- Overall, the current reorganisation involves changes to many aspects of local health economies simultaneously. Many of these changes are occurring at different rates (eg CCGs are more developed than local Heathwatch in most areas), and it will therefore be some time before the new relationships can be fully defined and functional.

Approaches to commissioning and contracting
CCGs have not yet taken formal responsibility for commissioning and contracting. We found that:

- Most case study sites had been through some sort of prioritisation process for commissioning, which informed their ongoing strategic plan.
- In the second survey, three quarters of CCGs had already, or planned to, set up new services in the next 12 months and two fifths had changed or planned to change some providers of existing services.
- Most changes to services to date reported by the survey respondents and observed in the case study sites had been small in scale, short term pilots or linked to local enhanced services or innovation funding and only small scale decommissioning had occurred if at all.
- Commissioning was in a state transition and tensions could be seen between the various levels of organisation (ie PCT Clusters, CCGs and Localities) in some casae study sites.
- Many of the case study sites made claims about the 'added value' of having clinicians (almost exclusively GPs) involved in both commissioning and contracting. It is too early for there to be any evidence to back up these claims.
- There were some issues caused by time constraints faced by GP commissioners, and case study GPs were beginning to realise that their new role will mean shouldering greater responsibility and accountability for commissioning decisions

Conclusion
Our study has shown that there has been a great deal of hard work undertaken by both GPs and managers involved in the development of CCGs. The picture is one of flux, with ongoing change affecting the emerging CCGs themselves, as well as the wider context around them. There is an ongoing commitment to the idea of GP-led commissioning (we found little evidence of involvement of other clinicians), with evidence of enthusiasm for involvement in local service development. Some claims were made about the added value that GPs bring to the contracting process, which it is currently too early to verify. The most difficult aspect of the process as experienced by our participants was the fact that many aspects of the NHS (and associated Local Authority structures) have been changing at the same time, generating disruption and confusion. We have highlighted in this report the issues that arose for our respondents as they moved through each stage of the process so far. We were told that GP involvement in commissioning was already being strengthened prior to the current reorganisation, and many respondents expressed the belief that many of the objectives of the current changes could have been achieved within existing structures. This research reports the very early stages of the development of CCGs, and must be interpreted with this in mind. However, we believe that many of the specific issues highlighted in our results will continue to be pertinent to the ongoing development of the new system architecture.

Lessons relevant to the further development of CCGs
We draw the following lessons from our findings:

- Implementation processes such as the Pathfinder approach, that aspire to actively engage front line staff in shaping the direction of travel, carry with them the risk of raising expectations that may not be met, resulting in disillusion for the staff involved. This risk may be mitigated by ensuring that there is clarity for all involved over which aspects of the programme are open to modification and which are the subject of higher level strategic decisions. In addition, ways need to be found to ensure that those who do engage at an early stage in providing active feedback continue to feel valued throughout the later stages of the process.

- CCGs would welcome greater clarity and timeliness of guidance. Whilst they do not want to be directed from above, they would like a clearer statement of what the eventual overall structure will look like, with clear guidance as to what is and is not 'allowed'. Within this clear structure they would like to be given the autonomy to innovate and develop their own local organisational responses.

- CCGs would also welcome greater clarity over the new role of the NHS Commissioning Board and its relationship with CCGs.

- The NHS Commissioning Board should identify specific points of contact for local CCGs. Personal contacts are valued, and CCGs are keen to be able to get to know and work consistently with particular local NHS Commissioning Board personnel.

- Clarity is required urgently over the employment destinations of managerial/commissioning staff. Experienced and valued staff members are under great strain and some are leaving due to the uncertainty about their employment prospects.

- At a local level, the process of clarifying roles and responsibilities between CCGs and their developing CSS needs to be expedited.

- The NHS Commissioning Board could usefully encourage CCGs to pay attention to their membership, including the developing role of their Locality groups/Council of Members. In the longer term, the ability of CCGs to change GP behaviour will depend upon their perceived legitimacy, which in turn depends upon the approach that they take to engaging members.

- Our research suggests that CCGs need to consider: the degree of autonomy devolved to Localities; the role of the members in contributing to strategy development; approaches to quality improvement/performance management; and the extent to which the CCG may be a vehicle for the transfer of expertise and resources between practices.

- In order to develop a new generation of clinical leaders, NHS Commissioning Board resources could usefully be devoted to encouraging a model of incremental engagement that builds upon GPs' commitment to local clinical innovation. In addition, these aspirant leaders will require ongoing access to training and development support

- CCGs need to provide opportunities for aspirant leaders (including female GPs, non-principal GPs and other health care professionals) to become engaged in commissioning activities in an incremental way

The rapid pace of change and the short timescale over which the research has been conducted have been challenging, and this report therefore presents a picture of a changing landscape. However, the data collected have been both detailed (in the case study sites) and broad (in the surveys) in scope; we are therefore confident that the findings presented here are relevant to the wider population of CCGs.

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1 Background and Context

1.1 Introduction: aims and research questions

This report presents the findings from a study of developing Clinical Commissioning Groups in England, The aim of the study was to explore the early experiences of emerging Clinical Commissioning Groups (CCGs) as they set themselves up as 'Pathfinders' and moved towards authorisation, investigating the factors that had affected their development and drawing out lessons for the future. The full list of initial and additional research questions can be found in Appendix 1. The specific research questions addressed in this report are:

- What have been the experiences of Pathfinder CCGs over the past year?
- What factors have affected their progress and development?
- What approaches have they taken to:
    - Being a membership organisation?
    - Developing external relationships?
    - Commissioning and contracting?
- What lessons can be learned for their future development and support needs?

1.2 Research challenges

First mooted in July 2010, the setting up and development of Clinical Commissioning Groups has not been without controversy. Following the initial publication of the Health and Social Care Bill, a 'pause' in the legislation was announced for further consultation. This 'pause' also impacted upon the research, delaying the start of data collection from June 2011 until Sept 2011; data was therefore collected between September 2011 and June 2012. During this time CCGs have been developing rapidly, and the mixed methods used in the study (combining detailed qualitative case studies with wider cross sectional surveys) have generated rich and nuanced data. However, they present a number of difficulties when it comes to analysis and presentation of the results. In particular, complex and difficult issues have arisen in our case study sites, dominated the agenda for a time and subsequently been resolved. Presenting evidence relating to these issues is difficult: focusing upon problems that have been resolved may seem uninteresting, but to ignore them would miss the valuable opportunities for learning that this longitudinal approach provides. This report, therefore, adopts a hybrid approach, presenting some data in temporal sequence, but adopting a thematic approach to those issues which have changed little over the course of the study. The first section of the results will provide a description of the journey undertaken by our case study sites, describing and explaining the phases of their organisational development and exploring the factors that helped or hindered their approach to meeting the challenges faced at each stage. Data from the wider population of CCGs obtained from the survey will be used to contextualise and broaden this analysis.

In addition, there has been a significant challenge associated with terminology. As emerging CCGs have developed they have adopted a variety of words to describe their structures, key personnel and processes. These vary greatly between sites, and words are often used differently by those on the ground than they are by those working on national programmes relating to commissioning or in official documents. It became clear early in the research that even those bodies or structures given similar names were rarely directly comparable, and some of the terms used are unique to particular sites, and so cannot be used if anonymity is to be maintained. In addition, there are some terms (such as 'Governing Body') which are developing an officially sanctioned meaning, but which are still used quite variably on the ground. After careful analysis of the structures in our case study sites we have identified a

number of different 'levels' of working which seem to be represented in all our sites, regardless of the names adopted. In order to enhance comparisons between sites we have therefore adopted the following descriptors:

- *CCG* – emerging Clinical Commissioning Group, technically established as a subcommittee of the PCT Cluster
- *'Assurance' leve*l – a body planning to take over the statutory responsibility once authorisation completed. Primary activity is to receive reports from 'doing' level and assure themselves that the work of the CCG is being undertaken satisfactorily. In smaller CCGs, formally constituted bodies at this level may also undertake some 'doing' activities themselves
- *'Operational' level* – level at which the business of commissioning is conducted. This may include a number of different committees or workstreams. In addition, in some sites there may be a formally constituted operational group of some kind containing a subset of the assurance level group, and there may be informal groupings of senior managers and/or GPs/other clinicians who meet more informally
- *Council of members (CoM)* – group of practice representatives
- *Locality group* – smaller group of representatives from a geographical area within the CCG. May have some 'operational' responsibilities.
- *Advisory group* – wider group of stakeholders (clinical and non-clinical) convened by the emerging CCG to provide advice or guidance

1.3 Policy context

A large number of guidance and other documents have been produced over the past year. In Table 1 we present a timeline of key events and published guidance, providing links to the relevant documents. In this section we then highlight those parts of the guidance that have had most impact in our research sites and which are important in understanding the research evidence presented in this report. This provides the context within which CCGs have set themselves up, developed and moved towards authorisation.

Table 1: Timeline showing key events, documents and guidance

July 2010	The Government published the NHS White Paper "Equity and excellence: Liberating the NHS". http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf
7 October 2010	The Government published guidance to assist PCTs and CCGs in implementing QIPP agenda – "Strategies to achieve cost-effective prescribing: Guidance for primary care trusts and clinical commissioning groups". http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_120214
October 2010	GP Commissioning Consortia could put themselves forward to be 'Pathfinders'
15 December 2010	The Government published responses to the consultations on the White Paper. This document is setting out how they will legislate for and implement the reforms - "Liberating the NHS: Legislative framework and next steps". http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122661
Dec'10-June 11	Pathfinder learning events held
19 January 2011	Health and Social Care Bill 2011 introduced in the House of Commons. http://www.publications.parliament.uk/pa/cm201011/cmbills/132/11132.pdf
10 March 2011	The Government published a document setting out the functions of CCGs: The Functions of GP Commissioning Consortia: A Working Document http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124979
4 April 2011	The Government announced a 'pause' in the legislative process.
6 April 2011	NHS 'Future Forum' was launched as part of the Government's listening exercise on the Health and Social Care Bill.
June 2011	NHS Future Forum published key recommendations followed by the Government response to the report. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127443
Autumn 2011	Resumption of the passage of the Bill
4 August 2011	The Government published a self-assessment tool for emerging CCGs. (this was updated in June 2012) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_129124
August 2011	Letter from Barbara Hakin to PCT and SHA Cluster Chief Executives, specifying that CCGs should formally be set up as sub-committees of the PCT Cluster (Hakin 2011) https://www.wp.dh.gov.uk/healthandcare/files/2011/09/20110824-dear-colleagues-clarification-note_gateway16529.pdf
14 September 2011	The Government published interactive running cost assessment tool - "Clinical Commissioning Groups running costs tool: A Ready Reckoner". http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_129992
30 September 2011	The Government published guidance setting out early thinking on the authorisation process including the 'domains' under which CCGs would be assessed. "Developing clinical commissioning groups: Toward authorisation". http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130293
24 November 2011	The Government published "The Operating Framework for the NHS in England 2012/13". http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131428.pdf
2 February 2012	NHS Commissioning Board first published the following guidance: - "Developing commissioning support: Toward service excellence". http://data.parliament.uk/DepositedPapers/Files/DEP2012-0954/PQ111107.pdf - "Towards establishment: Creating responsive & accountable clinical commissioning groups". http://www.commissioningboard.nhs.uk/files/2012/01/NHSCBA-02-2012-6-Guidance-Towards-establishment-Final.pdf
10 March 2012	The Government published a working document describing the proposed statutory functions of GP consortia – "The functions of GP commissioning consortia: A working document". http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124979
27 March 2012	Health and Social Care Bill received Royal Assent.
29 March 2012	Health and Social Care Act 2012 - http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm
April 2012	NHS Commissioning Board published the following guidance: - "Clinical commissioning groups governing body members: Role outlines, attributes and skills". http://www.commissioningboard.nhs.uk/files/2012/04/ccg-mem-roles.pdf - "Clinical commission group authorisation: Draft guide for applicants". This is a final draft guide for CCGs applying for authorisation.. http://www.commissioningboard.nhs.uk/files/2012/04/ccg-auth-app-guide.pdf
May 2012	The Government published CCGs HR Guide.http://www.commissioningboard.nhs.uk/files/2012/05/ccg-hr-guide.pdf

1.3.1 The Pathfinder 'programme' – nature and intent

The Health White Paper, Equity and Excellence (Department of Health 2010 proposed the transfer of the responsibility for commissioning to groups of GPs (initially known as GP Commissioning Consortia, GPCC), and set out plans for the abolition of both Primary Care Trusts and Strategic Health Authorities. It was also proposed that an arm's length body known as the NHS Commissioning Board (NHSCB) would be set up with responsibility for overseeing GPCC and for commissioning more specialised services and primary care itself. The timescale proposed for these changes was as follows (Department of Health 2010: p30):

- a comprehensive system of GP consortia in place **in shadow form during 2011/12**, taking on increased delegated responsibility from PCTs;
- following passage of the Health Bill, **consortia to take on responsibility for commissioning in 2012/13;**
- the NHS Commissioning Board to make **allocations for 2013/14 directly to GP consortia in late 2012**; and
- GP consortia to take **full financial responsibility from April 2013.**

The language relating to GPCCs in the White Paper was permissive, emphasising the need for them to develop from the bottom up, free from central direction. This tone was re-emphasised by a subsequent letter from the then Chief Executive of the NHS, Sir David Nicholson in September 2010:

> 'We would want to enable new organisations, and particularly GP consortia, to have the maximum possible choice of how they operate and who works for them. It is important that GP practices be given time and space to develop their plans to form commissioning consortia. PCTs should provide support for this process and empower consortia to take on new responsibilities quickly when they are ready to do so, but it is important that solutions develop from the bottom up and are not imposed from above. GP commissioners should have the freedom to arrange themselves as they see fit to best meet the needs of their local populations' (Nicholson 2010:5)

In October 2010 it was announced that groups of GPs wishing to form a Commissioning Consortium could put themselves forward to be 'Pathfinders', charged with testing different design concepts and identifying areas of learning to inform the programme overall. Early documents about the programme seemed to imply that 'Pathfinders' might be a cadre of early adopters (or 'pioneers'), with a letter issued by Dame Barbara Hakin in October 2010 stating that:

> 'The objective of establishing pathfinders is to empower pioneering groups of GP practices that want to press ahead with commissioning care for patients. Specifically the programme will:
> • identify and support groups of practices that are keen to make faster progress, under existing arrangements, and can demonstrate their capacity and capability to take on additional responsibility for commissioning services, in line with the proposals set out in Equity and Excellence: Liberating the NHS;
> • enable GPs, working with other health and care professionals, to test different design concepts for GP consortia and identify any issues and areas of learning early so that these can be shared more widely;
> • create learning networks across the country to ensure that experience and best practice are spread and specifically that pathfinders support other local groups that are less developed, and
> • involve these front line clinicians more in delivering the QIPP agenda.'
> (Hakin 2010)

There was an explicit aspiration that the Pathfinder approach should be an open and collaborative one. In an interview in December 2011, a senior member of the Commissioning Development Transition Team explained that the approach was one based upon the action learning paradigm, in which groups of Pathfinder CCGs were engaged in events and in online fora in order to feedback their experiences and contribute to the ongoing development of policy, as well as sharing learning about what went well or otherwise in the implementation process. Learning from networking events was used to inform further guidance, and fed into the development of the authorisation process. Learning events were held from Dec 2010-June 2011, and CCG development events from Dec 2011-Jan 2012. The Pathfinder programme published a regular bulletin and established a website.

In December 2010 the government published its responses to the consultations on the White Paper (Department of Health , Cmd 7993 2010). This document again emphasised the freedom of GPCC to develop as wished, stipulating only that they should have a recognisable geographical footprint (p53) and a written constitution (p60) which would be assessed for suitability by the new NHS Commissioning Board. Further guidance was promised on this issue. It was also made clear that no stipulation as to the desired size of GPCC would be made. This document also further identified the task of 'Pathfinder' GPCCs, suggesting that they should: test out design concepts for GPCC; explore how consortia can develop effective relationships with constituent GP practices and local government, patient groups and secondary care clinicians; embed and reinforce the importance of engagement with patients and the public and local partnership working with local authorities; explore how consortia can best commission services at different geographical levels; demonstrate how clinical leadership of commissioning can improve care, reduce waste and deliver value; explore good practice in governance arrangements; design their new organisational structures; explore how best to secure the skills and expertise they need, including the human resources issues involved in the transition from PCTs; take on increasing delegated responsibilities from PCTs; provide a platform to share learning across the GP community (p 87). The experiences of Pathfinder CCGs as they took part in this process will be highlighted in this report.

It was clearly stated that GPCC would be able to choose their own commissioning support (p87):

> It is important to note that it is GP consortia that will have the power to decide what commissioning support they want, and from whom. Transitional support arrangements from PCT clusters need to be set up with that clearly in mind, with emerging consortia acting as customers

This document also clarified the fact that GPCC would eventually have to demonstrate their capability to take over commissioning to the NHS Commissioning Board in order to be 'authorised', but emphasised that: 'the Board will have an obligation to approve any applications that meet the required criteria' (p92). In February 2011 a further letter from Sir David Nicholson (Nicholson 2011) clarified the arrangements for 'clustering' PCTs, and encouraged PCTs to assign managerial and commissioning staff to work with GPCC in developing their structures and processes. The impact of the developing complexity in managerial and commissioning support arrangements will be explored in the report.

1.3.2 Key aspects of developing guidance that arose in case study sites

Following the legislative 'pause', further guidance was issued to CCGs as set out in the timeline above. The key elements of this guidance that had a significant impact in our case study sites were as follows:

- The specification that CCGs should be formally set up as a sub-committee of the PCT Cluster (August 2011)
- The publication of the authorisation timetable and domains (Sept 2011) (NHS Commissioning Board 2011). These are set out in Box 1:

Box 1: Authorisation domains

Domain 1: A strong clinical and multi-professional focus which brings real added value.
Domain 2: Meaningful engagement with patients, carers and their communities.
Domain 3: Clear and credible plan which continue to deliver the QIPP challenge within financial resources.
Domain 4: Proper constitutional arrangements with the capacity and capability to deliver all their duties and responsibilities.
Domain 5: Collaborative arrangements for commissioning with other CCGs, local authorities and the NHSCB as well as appropriate commissioning support.
Domain 6: Great leaders who individually and collectively make a real difference.

Within each domain, aspirant CCGs would be expected to produce a range of evidence, including documents such as plans and proposals, examples of work undertaken and feedback from local stakeholders.

- The publication of an interactive spreadsheet allowing CCGs to model their potential running costs, based upon differing population sizes and other variables such as governing body size (Department of Health 2011c)(Sept 2011).
- The publication of the NHS Operating Framework (Oct 2011)suggesting that the running costs available to CCGs would be set at £25/head (considerably less than the running costs of many PCTs)
- Guidance relating to the development of governance processes in CCGs (NHS Commissioning Board 2012e)(Feb 2012). The key elements of this guidance included the following:
    - The need to have a defined geographical footprint in order to commission for unregistered populations
    - The need to have in place arrangements to include member practices in decision
    - The issues to be addressed in a constitution, including: arrangements to ensure transparency; provision to hold meetings in public; the requirement to appoint an audit and a remuneration committee; arrangements for the appointment of relevant sub committees if required
    - Safeguards against conflicts of interest
    - The key issues to be considered in appointing a governing body
    - The requirement for three overall 'leaders', including the need for a Chair, an Accountable Officer and a Chief Finance Officer. A number of requirements are set out with regard to these posts: the Accountable Officer (AO) may be a from any disciplinary background, including GPs or managers ; either the AO or the Chair should be a clinician; if the Chair is a GP, there should be a Lay Deputy Chair; if the AO is a clinician, then there will also need to be a senior

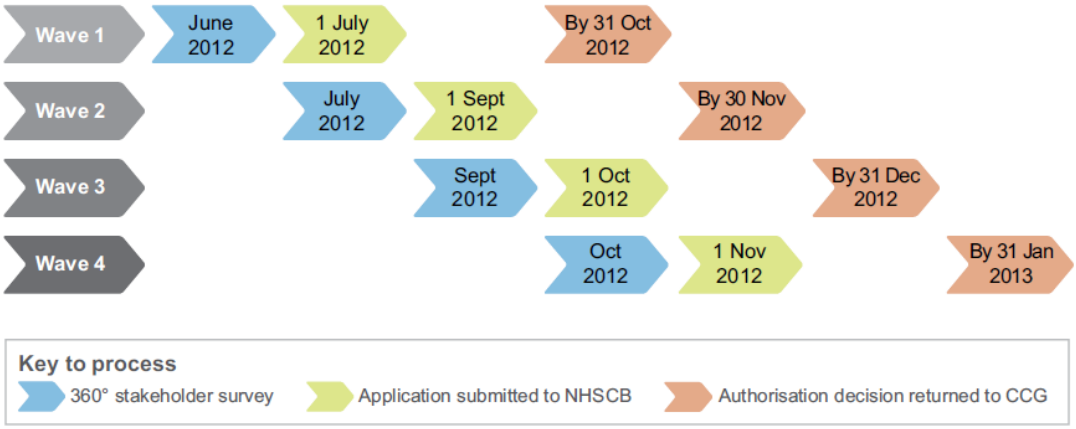
manager in the leadership team. It is stipulated that the use of the term 'Chief Executive' to describe this person is discouraged.

- Further guidance about the development of Commissioning Support Services (CSS) (NHS Commissioning Board 2012d)(Feb 2012). This guidance stipulated that developing CSS would be hosted by the NHS Commissioning Board until 2015
- Further guidance relating to the 'three at the top posts' (NHS Commissioning Board 2012b) (April 2012). Initial guidance was interpreted in our case study sites as suggesting that CCGs would choose their own leaders, who would be assessed for suitability by a national process and then appointed. However, further guidance issued in spring 2012 made it clear that, following assessment, nominated Accountable Officers and Chief Finance Officers would also have to go through an open recruitment process, during which others interested in the post could apply. This was not expected by the CCGs in our study.
- Final guidance about the authorisation process (NHS Commissioning Board 2012a) (April 2012), including the evidence required under each domain and the timeline (see Figure 1)

Figure 1 timeline for authorisation (NHS Commissioning Board 2012)

6.1 There will be four opportunities to apply for authorisation in 2012:

Fig. 2 Authorisation application process per wave



- Further guidance about the human resource issues associated with the transfer of staff from PCT Clusters, with specific advice ot work to limit the number of staff facing redundancy (NHS Commissioning Board 2012d) (May 2012)

In addition to this national level guidance, our case study sites also received guidance from their local SHA Cluster, which was sometimes more detailed than the national level guidance, and, on occasion, conflicted with it. Where relevant examples are given in this report.

1.4 The structure of the report

The report is structured to answer the research questions listed in section 1.1. This introduction is followed by a description of our methods. The results are then presented. The first section of the results is structured chronologically, describing the issues that arose and were important as the CCGs developed. This is followed by an analysis across the cases of the factors that were found to affect progress and development. A third section then provides more detail relating to the experiences of being part of the Pathfinder programme. The final

three sections of the results present the findings relating to those issues which were less time-dependent, drawing out thematically the evidence that we found relating to: the concept of being a ‘membership organisation; external relationships; and approaches to commissioning and contracting. A discussion section then summarises these findings and links them together, with a final section presenting our conclusions and suggestions of lessons for the future.

Throughout the report evidence gather from all of our data sources is presented together, providing a detailed analysis based upon the case study findings as well as an assessment of the wider population of CCGs based upon surveys and telephone interviews.

2 Methods

2.1 Overall research design

The aim of the study was to understand in depth the experiences of Pathfinder CCGs. Our prime method was a case study approach, carrying out eight detailed case studies in CCGs across England. Case studies are recognised as the method of choice to capture the complexity associated with organisations that were coming into being and developing throughout the study (Stake 1995). This approach allows in-depth and contextualised examination of phenomena, which is important to gaining a clear understanding of change processes (Yin 2003). However, the current NHS changes are happening at different rates and in different ways across the country; it was therefore also important to capture a broader picture of the developing structures and processes across the full range of developing CCGs. We therefore also undertook two wider web surveys, carried out in December 2011 and April/May 2012. In addition, qualitative telephone interviews with a randomly selected sample of CCG leaders were carried out towards the end of the research period. The object of the web surveys was to collect descriptive data about the wider population of CCGs that would allow us to compare our deep and detailed knowledge from the case studies with the wider context; the object of the telephone interviews was to enable us to follow up in greater depth and with a wider range of respondents some of the issues that emerged from the case studies. The approach could be characterised as a 'deep dive' in eight sites, providing a comprehensive picture of their development, alongside a broad assessment of the wider population. The initial survey questions were developed out of our experiences in the early months of the qualitative case studies, allowing us to ensure that the questions asked were relevant. There was a significant focus in this survey on early decision making by the groups, including, for example, their rationale for forming in particular ways. The second survey contained a number of questions about CCG structures which broadly repeated those asked in the first survey, in order to capture important changes. In addition, more detailed questions were asked about the development of commissioning activity. Both survey instruments are provided as appendices. The telephone interviews were designed to allow us to explore across a wider sample of participants the findings emerging from the case studies and surveys, and the interview schedule was based upon these emerging findings (see appendices). In practice this phase proved difficult, not least because there was a significant delay in obtaining CCG contact details. At the time of writing this report just over half of the telephone interviews had been carried out. They were not included in the detailed analysis, and this report only provides descriptive information from the interviews where such information is felt to add useful wider context. Since completing the report, further assessment of the telephone interview data has confirmed that qualitative 'saturation' (Murphy et al 1998) had been reached, with the later interviews adding no new information that had not been obtained from other sources.

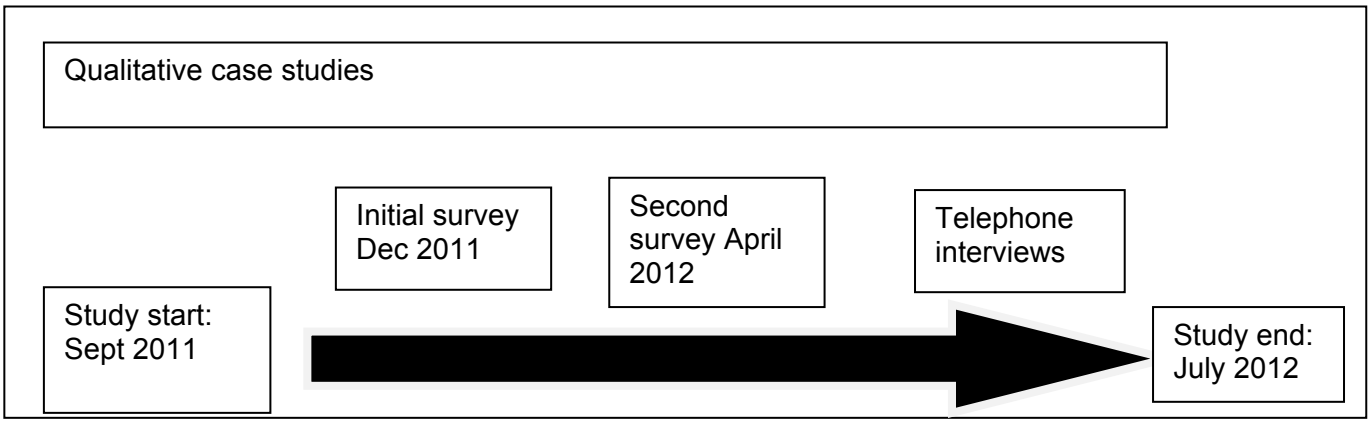
Together these data sources provides a comprehensive picture of the development of emerging CCGs from the early stages following their setting up as Pathfinders to the eve of the first applications for authorisation. Whilst this approach might legitimately be called 'triangulation' we regard the value of collecting data from multiple sources in this way as providing as opportunity to broaden and deepen the findings rather than as a simplistic test of 'validity' (Murphy et al 1998).

Ethical approval was obtained from NHS Research Ethics service (study number 11/NW/0375), and research governance approval was obtained for each case study site.

In the results that follow, detailed data from the case study sites will be used to explore and explain the issues affecting CCGs as they developed. This will be supplemented by the data from the surveys, showing how the factors identified played out in the wider population. It is important to note that, whilst the structures and processes developing in our case study sites

do vary considerably (as might be expected given the deliberately 'permissive' Pathfinder approach), the issues that arose and had an impact in the sites were very similar across the sample, and the approaches to tackling these issues were often also similar in spite of very different structures, processes and contexts. Furthermore, the data gathered from the various surveys also tended to confirm and further develop these findings, with, for example, the emerging data from the (ongoing) telephone interviews providing insights that mirror and confirm the data gathered in the case study sites. We therefore believe that this study represents a relatively comprehensive picture of the first year of CCG development, leading up to applications for authorisation.

Figure 2 Research timeline



2.2 Qualitative case studies

We selected a purposive sample of eight 'pathfinder' commissioning CCGs in England as participants for the qualitative case studies. In order to provide a sample that reflected the developing complexity on the ground, the sample was structured to incorporate the following dimensions:

Table 2: Case study selection criteria

Property	Dimensions	Justification
Size	2nd - 5th quintile population as at July 2011 (excluding the lowest quintile)	The optimum size for commissioning organisations would appear to be different for different functions. For example, risk sharing may require a larger population whilst mutual performance management may be easier in a smaller group. Structures and governance procedures are likely to be different between large and small consortia, as are approaches to commissioning and to collaborating with neighbouring consortia.
Is there are formal federation of practices?	Formal federation or not	CCGs that have formally federated will need to develop procedures for governance, decision making and sharing of information, and this may be different from those consortia which are informally collaborating.
Socio-demographic profile and deprivation	Homogeneous area or heterogeneous area	CCGs in which levels of deprivation are widely different across the area will face different internal and external challenges than those responsible for a homogeneous population
How many major providers of secondary care do they historically use? (note large urban areas are more likely to have a number of major providers, whilst rural areas and small towns are more likely to relate to a single local provider)	One or more than one	Approaches to commissioning are likely to be different in areas where there is a single dominant provider than in areas with existing competition between providers
How many Health and Well Being Boards is the CCG likely to need to relate to? (note urban areas are likely to relate to a single Local Authority H&WB, whilst CCGs that include a rural area are more likely to cross LA boundaries)	One or more than one	Needs assessment will be done by H&WB, and CCG commissioning plans must be agreed between the two. It is therefore likely that CCGs relating to more than one H&WB will require different processes than those with a single H&WB
How close is the CCG to some previous administrative grouping?	Replicating previous grouping or not	Where CCGs have recreated old groupings there are likely to be significant historical relationships which have an impact on decisions about structures, processes and governance

In order to ensure that the research did not only cover early adopter groups, the sample included CCGs from more than one pathfinder 'wave' (including waves 1 and 5). We also included emerging CCGs from both urban and rural areas.

At the time of sampling (July 2011), the quintiles for population size were as follows:

Table 3: Quintiles

Quintile	Population size
1	**<88,000**
2	**88,001 – 138,000**
3	**138,001 – 185,000**
4	**185,001 – 278,000**
5	**>278,000**

Eight CCGs that manifested the spread of characteristics set out in Table 2 were selected; the pseudonyms and characteristics of these are set out in Table 4.

Table 4: Site characteristics.

Site	Size (quintile)	Pathfinder in federation?	Socio-demographic profile	Major providers	Local Authorities	Pathfinder wave
Site 1	3	No	Mixed	1	2	2
Site 2	5	Yes	Relatively homogeneous, pockets of deprivation	> 1	1	1
Site 3	5	No	Relatively homogeneous, affluent, pockets of deprivation	> 1	1	2
Site 4	2	Yes	Relatively homogeneous, deprived	> 1	1	1
Site 5	3	No	Relatively homogeneous, deprived	1	2	3
Site 6	2	No	Relatively homogeneous, affluent	1	1	5
Site 7	4	No	Mixed	> 1	1	3
Site 8	4	No	Mixed	1	1	1

We commenced collecting data in all sites between September and November 2011; as per protocol, data collection then continued until 21st May 2012. We collected data from three types of source:
Interviews with clinical commissioners, managers supporting commissioning and relevant partners such as members of local Health and Well Being Boards. As at January 2012 we had conducted 30 such interviews, increasing to 96 interviews with 92 individuals (some key individuals being interviewed more than once) by May 2012. Interviews were audio-recorded (unless the participant objected) and fully transcribed for subsequent analysis. All interviewees were given written information about the study and were asked to sign a consent form. This spread of data sources provided further triangulation, moving beyond the (often well-constructed) stories provided by those involved to also observe what actually happened in practice as the developing groups wrestled with the complex situation that they faced. Data were stored and managed with the assistance of Atlas.ti software, enabling the secure storage of data (on a University server) and providing a medium through which research team members are able to work together on the analysis.

- below shows the range of people interviewed during the research. We interviewed a wide range of different types of NHS manager including those aligned to the developing CCGs and those working in PCT Clusters. Their job titles included: PBC manager; finance; quality; workforce; business and performance; public health; corporate services; and commissioning and contracting. In addition, some had taken on roles managing their developing localities (e.g. locality lead). Interviewees included many individuals nominated for the roles of Accountable Officer and Director of Finance for the developing CCGs.

Table 5 Interview respondents by type

Type of respondent	Number interviewed	Number of interviews
Managers (NHS)	47	49
GPs	33	36
Lay members	5	5
Practice Managers	3	3
Nurse (Clinical lead)	1	1
Others (eg Trust manager)	1	1
Local Authority Representatives	1	1
Total	**91**	**96**

It should be noted that the fact that more managers were interviewed than GPs reflects the balance of personnel involved in CCG development. Managers approached for interview included those in leadership roles and those closely associated with the developing CCGs. As many GPs as possible were interviewed, and, although a few were unavailable for interview, the number above broadly reflects the number of GPs with active roles in the case study sites. We did not interview GPs who did not have active CCG roles. The small number of nurses and secondary care staff interviewed reflects the lack of involvement of these groups in CCG development so far. A small number of GPs and managers were interviewed twice, mainly in situations where particular sites had undergone significant changes since initial interviews were carried out.

- Observation of a variety of meetings (including those at assurance levels and operational levels) held by the CCGs and, wherever possible, meetings between representatives of CCGs and external bodies such as service development groups; meetings with PCT clusters and shadow Health and Well Being Boards; and meetings between the internal governing bodies and representatives of member practices. As at December 2011 we had observed 59 meetings (170 hours), increasing to 146 meetings (439 hours) by May 2012, across eight case study sites. Observations were recorded in contemporaneous field notes and written up by the researchers.

- Documents, including CCG governance agreements, policy statements, guidelines and accountability frameworks, as well as documentation associated with meetings (agendas, minutes, papers) were collected in all eight sites. We arranged for sites to provide us with these data in electronic format wherever possible.

This spread of data sources provided further triangulation, moving beyond the (often well-constructed) stories provided by those involved to also observe what actually happened in practice as the developing groups wrestled with the complex situation that they faced. Data were stored and managed with the assistance of Atlas.ti software, enabling the secure storage of data (on a University server) and providing a medium through which research team members are able to work together on the analysis.

Data collection and analysis for each case within the study have been undertaken in parallel, allowing the team to modify and develop the data collection frameworks as appropriate, following up significant findings and seeking contradictory or confirmatory examples. Analysis

was undertaken jointly by the team, facilitated by regular face-to-face team meetings and Skype conferences. Nineteen such meetings/ conferences were held between September 2011 and May 2012. Transcripts and fieldnotes were read repeatedly for familiarisation, and coded according to an initial framework based upon our research questions, our knowledge of the literature in this area and from our reading of relevant policy documents. In addition, inductive coding allowed us to capture unexpected themes. Coding definitions and emerging theoretical ideas were discussed and refined at team meetings. Both fieldnotes and interview transcripts were coded in this way. In addition, the team maintained ongoing summaries of the case study sites under headings derived from the developing analytical framework. These were updated regularly, and discussed at the team meetings. This allowed us to maintain ongoing cross-case comparisons, and aided in the handling of such large amounts of data. Emerging analytical ideas were set out in memos, and these were tested amongst the research team members and refined. Coded data were then further read and analysed by a number of team members in order to ensure consistency of approach, and the PI repeatedly read the whole data set in order to further refine and develop the emerging analysis. As the analysis progressed and recurring themes were identified, the overall structure of the results section of this report was developed during team meetings, and tested against the ongoing analysis of the data. In the writing of the report, relevant coded segments of data were read and reread by the PI and research team, and the boundaries and characteristics of the recurring themes were explored. Findings under each heading were repeatedly tested back against the raw data to ensure that a balanced picture was emerging, and where there was a dichotomy of views expressed, similarities, differences and any underlying explanations were explored. Data segments which illustrate these themes have been included in the report. Once the dominant themes were identified, the survey data was examined in order to explore the extent to which the findings were reflected in the wider population of CCGs, and these data are used in the report to provide the relevant context. Additional descriptive data from the surveys and telephone interviews are included where relevant.

2.3 Web-based surveys

We carried out two web-based surveys with emerging CCGs during the research period. The first was in December 2011 and the second during April / May 2012. Both web surveys were constructed using the Survey Monkey web survey tool. Questions for the surveys were discussed by the team, before being piloted with selected experts and submitted to the project Stakeholder Group for comments. The link to the survey was sent electronically to named contacts in all emerging CCGs in England using contact details provided by the DH (an updated list was used for the second round). In total three additional email reminders were sent out for each survey. The first survey focused largely on factual data, such as size, origins of the groups and details about early governance structure. In addition, questions were asked about the groups' experiences of the support available from the Pathfinder programme. Finally, questions were asked about initial priority areas. In the second survey the factual questions were repeated in order to capture changes in configuration, and more details were requested about emerging governing body membership. In addition, respondents were asked to provide details of any commissioning/decommissioning decisions taken, and to explain their plans in relation to managerial support. Both surveys are included as appendices.

We obtained 104 complete or partial responses out of a total of 253 invitations sent out to survey one. This represents a response rate of 41%. The survey was closed on 21/12/2011, having run from 5/12/2011. For the second survey we gained 118 complete or partial responses from a total of 209 invitations, giving a response rate of 56%. Analysis of the data suggested that the size and composition of the CCGs responding to the second survey broadly mirrored that in the wider population, suggesting that there is no systematic bias in the results obtained, at least in this dimension. However, the response rate must be borne in

mind in interpreting the results. This survey ran from 20/04/2012 and was closed on 21/05/12. The second survey was preceded by a questionnaire piloting stage. The 8 CCGs constituting our case study sites were invited to provide feedback on the pilot version of the questionnaire, of which 6 responded and have been included in the total number of respondents to the second survey.

Analysis of the surveys did not include any statistical tests or comparisons. The data obtained were descriptive, and have been used in the report to contextualise the findings from the qualitative case studies by, for example, providing evidence about the extent to which governance structures found in the case studies were mirrored elsewhere, and providing wider evidence about the impact of the Pathfinder support programme. Some of the more detailed data (such as that relating to commissioning decisions) was beyond the scope of this report, and will be written up separately for publication.

2.4 Telephone interviews

In addition to the online surveys, between May / July 2012 we also carried out 38 follow-up qualitative telephone interviews among a random sample of CCGs. In order to select a sample, several simple random samples of 100 CCGs were drawn from an updated list of CCGs used for the second survey (n=209) utilising the SPSS statistical software. Subsequently, the samples were compared with the population with regards to location and population size of the CCGs. The sample with the closest distribution of these two variables to the whole population was chosen. The lead GP in each chosen CCG was interviewed.

The response rate amongst the 100 randomly selected CCGs was 38%. There was a delay in starting the telephone interviews as we were awaiting contact details from the DH, and so they were carried out between 01/05/12 and 6/7/2012, and were only completed after the first version of this report was submitted. The aim of the interviews was to gain a more in-depth insight into some of the issues explored in the online surveys such as the history of the CCG, governance arrangements and the experiences of the Pathfinder Programme, and to obtain further clarification on issues that had arisen in the case studies. The telephone interview schedule is included as an appendix. The interviews were recorded where consent was given by the respondent and following this the interviewers filled in a data capture template. For this report, the data templates were read by the PI, and those aspects of the data covering areas addressed in the report were analysed. In particular, we looked for evidence to confirm or contradict conclusions drawn from the case studies, and this data is included in the report to provide additional context. In addition, some questions were asked which sought to expand or explain some issues that had arisen in the survey data, such as possible explanations for the gender balance on CCG Governing Bodies, and the role of localities, and this is included in the relevant section of the report. Further analysis of the telephone interviews following the initial submission of this report confirmed that data saturation had been reached, with no new themes or findings arising from the data. The only exception to this is that, when asked about their aspirations for ongoing support from the new NHS Commissioning Board, a number of telephone interviewees suggested that they were looking for clarity surrounding the management of the GMS contract and the role of CCGs in the performance management of practices. This was not an issue that had arisen to a significant extent in the case study sites, but it is our belief that it arose due to the timing of this phase of data collection; at around the time of the telephone interviews, CCGs were finalising their internal constitutions ready for authorisation, and it may be that this explains their interest in this issue.

2.5 Presentation of data

This report relies heavily on the presentation of direct quotations from interviews and of excerpts from meeting notes. These have been chosen for presentation according to two principles. Firstly, data are presented where they are typical of responses seen, and

secondly they are included where they illustrate an unusual or contrasting issue. The use of this material gives a strong flavour of the nature and content of discussions in emerging CCGs and gives a voice to the participants in this process. At the outset of our field research we undertook to preserve the anonymity of our participants. This has been a strong and guiding principle throughout the research as we wanted to ensure that all involved could speak freely. Care has been taken that the anonymity of research participants has also been maintained in the presentation of this report. Thus quotations and excerpts are labelled with an ID number and a generic description of the source e.g. 'Executive meeting' or 'manager'. The reader therefore cannot attribute particular quotations or excerpts to particular sites. The range of ID numbers (1-347 for interviews and M1-M39 for fieldnote extracts) used in the report shows the reader that these findings are based on the opinions of a wide range of participants and a large number of meetings. As an additional check, for the final version of this report the balance between managerial and GP respondents in the data extracts presented has been checked. Overall, including meeting extracts and interview responses, the balance between GPs and managers in the data presented in the report mirrors the balance between these two groups in the CCGs which we studied. It is important to note that we found no systematic differences between the opinions and concerns of these two groups. Aspects of the data from the surveys and from the telephone interviews are included to provide wider context for the findings. We have tried to weave these into the report throughout rather than presenting them separately in order to present an overall coherent story of an unfolding process.

2.6 Limitations of the research

As will be seen from the report below, we have succeeded in collecting a large amount of data in a short period of time. This has been both a strength and a weakness. Our concentrated burst of data collection has enabled us to capture a vivid snapshot of organisational change. Furthermore, the triangulation of our case study data with evidence from two surveys and from telephone interviews provides a degree of confidence that our findings are relevant to the wider population of CCGs. The drawbacks of this have been that our work has been rapid and we have not always had time and space for reflection. The timetable for our research was also curtailed by: the 'pause' which delayed the start of our fieldwork; by the time taken in some sites to obtain research governance; and by the time taken to agree on the wording of our questionnaires.

This report is about the experiences of emerging CCGs and tracks their progress over a tumultuous period characterised by almost constant change. Ceasing the research work at the point at which sites were preparing to go through the authorisation process was an awkward place to stop. This report is thus about change and as such the accounts presented here are to some extent open ended. This work should thus be seen as marking a point in a process where further chapters are yet to unfold and be examined.

3 Results

In this section the results of the research will be presented. An initial chronological account will be followed by a summary of the overall 'Pathfinder Experience' and a discussion of the key themes that emerged across the case studies. Quotes from interviews and extracts from fieldnotes are used to illustrate the account where they either offer an example of something found throughout the data or something which was felt to be particularly interesting or noteworthy. Data from surveys and telephone interviews are included where they provide additional context. Each section is followed by a summary of the key findings.

3.1 The journey so far

3.1.1 Early stages: initial configuration

It was stated in the 2010 White Paper that the development of Clinical Commissioning Groups should be a 'bottom up' process, with GPs deciding for themselves with whom they wished to collaborate. The only requirement initially was that aspirant groups should have a defined geographical footprint. Our case study sites initially formed themselves into groups as follows:

Table 6: Initial configuration

Site	Initial configuration	Underlying logic
Site 1	Two previous PBC groups came together, crossing a Local Authority Boundary	Both groups focused upon a single Acute Trust, had worked together in the past and have similar populations
Site 2	Based upon a previous PBC group with multiple localities	History of successful working together. Regarded themselves as well advanced and wanted to build on previous successes
Site 3	Multiple previous PBC groups came together to form a single group. Footprint the same as the PCT (prior to clustering)	Large size important to maximise influence over local Trusts
Site 4	Previous PBC group (also had been a PCG and a PCT in the past)	Longstanding group that had worked together in many different administrative groupings. 'Like-minded' practices.
Site 5	A history of working together in a number of PBC groups, crossing LA and PCT boundary	Focused upon patient flows to local Acute Trusts
Site 6	Based upon a previous PBC group	History of successful working together, 'like-minded' practices
Site 7	Based upon two previous PBC groups who came together with a footprint the same as the PCT and co-terminous with Local Authority	Regarded co-terminosity with LA as important, and h/o working together in previous administrative groupings (eg GP multifund)
Site 8	Based upon a previous PBC group with multiple localities	Long history of working together, like-minded and focused upon a small number of Acute Trusts

Thus the key factors which appeared to be at work in shaping these choices were logics associated with a history of working together, along with a belief that Commissioning groups should follow patient flows. In many sites key individuals were also important in generating

enthusiasm and pushing the group forwards. This will be explored in more detail in section 3.2.1 below.

Key findings: Initial configuration

- Most groups set themselves up in ways which reflected previous administrative groupings
- Some of these dated back some time, including, for example, the recreation of Primary Care Group boundaries
- Mutual trust and shared history were regarded as a significant strength

3.1.2 Pathfinder application

Our 8 case study sites applied for pathfinder status as part of waves 1, 2, 3 and 5. In sites 3 and 7 the decision to apply to be a Pathfinder was led by the Primary Care Trust, whereas in the other sites the impetus largely came from an existing group of GPs, usually working together in a Practice-based Commissioning group with the support of PCT managers. Wave 1 sites gave the following reasons for applying to be a Pathfinder:

- To take advantage of extra money and support that it was anticipated would be available
- To obtain a 'badge' of recognition for the work that had been done in the past
- To obtain additional freedom to develop things as they wished

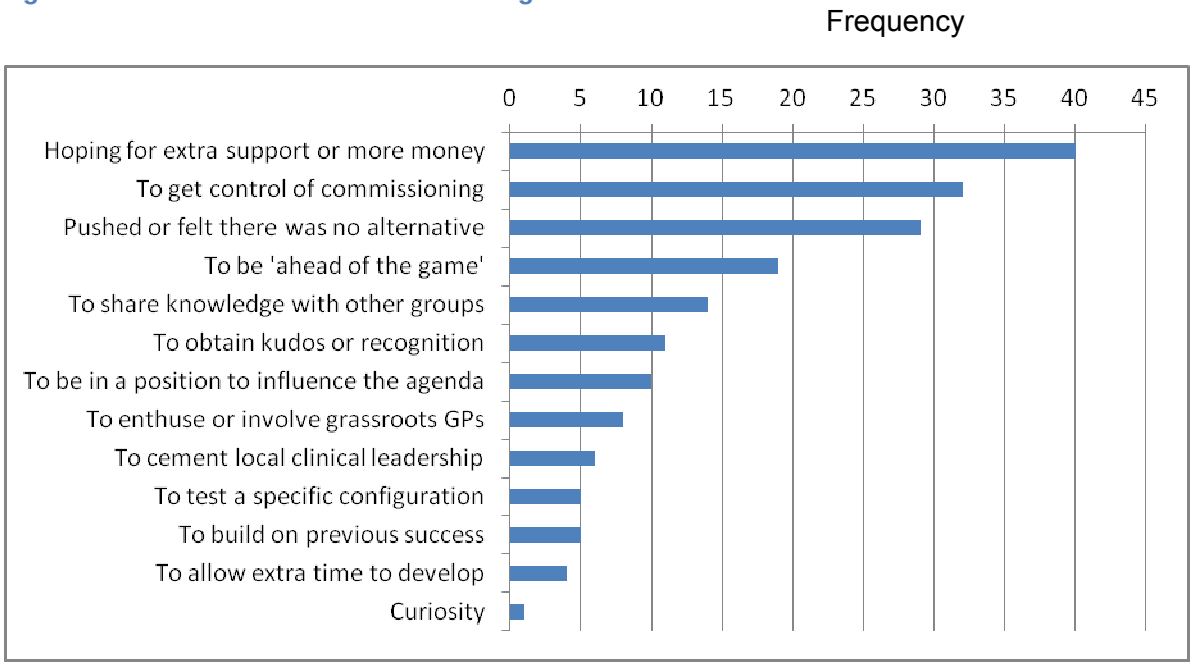
There was some competitiveness between aspirant CCGs, with one of our sites (a wave 2 applicant) telling us that:

> Well, no, that's how it was, what was…when the first wave were offered, we looked at it and said well, we don't really know where we're going at this moment in time, it's a bit too early for that. When we then looked at who had been given Pathfinder status, we certainly recognised locally that we were, as far as commissioning concerned, much more advanced than them, and therefore, there was nothing to say that we shouldn't go for a Pathfinder status. [GP ID 284]

One site decided to wait until wave 5 before applying to be a pathfinder. They explained that they were more concerned to concentrate on developing their structures than to take time out to fill in a Pathfinder application. When they did apply, they found the process encouraging, as it provided them with evidence as to the progress they had made.

In the December 2011 web survey, respondents were asked about their decision to become a Pathfinder, with the following results:

Figure 3: Professed reasons for becoming a Pathfinder



Several of our sites who had been early applicants told us that there had been an initial 'buzz' associated with being part of a new programme, but that this was lost quite quickly, as more and more 'Pathfinders' were authorised:

> A: No. My understanding, we were a first wave path finder. And, you know, that was great, you know, we had a trip to Downing Street, and all sorts of stuff, lovely…But, then, you thought, right, how are we going to be working with other first wave path finders, you know, what's the business here? And, then, they announced that there was going to be another [wave], and that was within weeks, another wave of path finders, so, now, you've got a second wave of path finders and I don't, quite, know whether there was any more money? Answer was, no. There was always as suggestion that there might be a bit more dosh to, actually, develop, you know, so… [but] you know, that didn't materialise.[GP ID 102]

Becoming a 'Pathfinder' was seen as a badge that had been applied for and achieved, but once most consortia had received the badge it was seen as having lost its significance:

> But, erm, if, if it had done what it said on the tin, that it was just for people that were at that level, then it would have been, if they'd have authorised only, say about 10 percent of the country were eligible, that's fine. I mean if you're part of that it would have been great. But because they've authorised nine waves now, it's like …Anybody with, and his dog can get it now. As long as you can tick a few boxes.[Manager ID 226]

In two of our eight case study sites the original application to become a Pathfinder was seen as a significant statement of their intentions, and was referred to in meetings.
In the others, however, the Pathfinder application was seen as a means to an end, and once they had been accepted it was not referred to again. Indeed, in one site the Pathfinder application had been made collectively by a number of groups acting as a federation, but in practice federated working did not happen. Over the course of the qualitative data collection we saw no obvious relationship between wave of Pathfinder application and subsequent pace of development.

Key findings: Pathfinder application

- Early Pathfinder told us that they believed that they would derive some benefit from being 'early adopters', but felt that this had been lost once the programme was extended
- Becoming a Pathfinder was generally regarded as a necessary 'badge' to be achieved, but which had little other significance

3.1.3 Risk assessment and running costs calculations

Pathfinder CCGs groups were subject to a 'risk assessment' by their Strategic Health Authority (SHA) in Oct/Nov 2011. This assessed them according to the following criteria:

- Demonstration of agreement between constituent practices
- The extent to which the CCG had a defined geographical boundary
- The relationship of the CCG to Local Authority boundaries, with those opting to cross such boundaries having the support of the LAs involved
- the size of the group, with large groups demonstrating how they intended to engage local practices and small groups demonstrating how they would be financially viable

At the same time, groups were encouraged to use the interactive spread sheet which allowed them to calculate their indicative running costs. In three of our groups this generated concerns about viability based upon size, with subsequent decisions made to merge with neighbouring groups. These discussions were invariably difficult, with participants in two out of the three sites affected indicating that they felt that 'pushed' rather than making the choice for themselves. Box 2
shows a detailed fieldnote of a discussion from a meeting which illustrates the issues, as CCG members discussed the outcomes from a meeting of a number of CCGs the preceding week:

Box 2: Merger discussions in one of our sites

[Nurse ID 252] said that there was difficulty in being a CCG on their own – 'we can't afford it'. They could share management, but not be a CCG alone. On Tuesday it felt like a 'fait accompli'
[PM ID 251] then said that they had looked at the running cost models provided by the DH on the 'ready reckoner'. Current guidance is that looking at the running cost estimates available (£25/head) they could not afford for [three local CCGs] to run their own statutory boards and to buy in the appropriate amount of commissioning support. BUT the actual figures are not out yet. If there were a smaller, slimmer board he feels that they could manage it. [neighbouring CCG] take a different view. They do not want to be standalone – they want to merge, as they feel that the available running costs are not enough. [three other nearby CCGs] have decided to merge. That leaves themselves and two neighbouring groups. They feel that [local 1] and themselves would 'respect each other's independence', and this would be the ideal merger, but the SHA 'say no, as it is not geographically contiguous'…
[PCT Director ID 262] said that she was 'disappointed' with the feedback from Tuesday's event. It was intended to be a discussion. 'You can carry on down the line of considering the option of being a stand lone group. However, you can't demonstrate that you would be able to set up alone as a statutory board. It would cost £1.5 million to set you up with a statutory board according to the figures. As the day went on it 'emerged' that it would be sensible to be considering different configurations. They are getting direction from the SHA and the DH that they must be satisfied that you can demonstrate:
** Affordability*
** Budget*
** Local authority agreement*
There had been discussion and debate, but a consensus emerged on the day about looking at the configuration of a merger between [three local groups]. What it should be called was not discussed. In October the SHA will be looking at the proposals to see if the configuration is 'viable'. They must demonstrate 12 months shadow running before they can become an authorised CCG. If they wish to be authorised in the first tranche in Oct 2012 they will need to have a viable configuration by October.
[Manager, ID 255] said that eventually there was consensus, not from the PCT but from the CCG chairs. They need to be pragmatic. A standalone group could not take on statutory functions. Went on to suggest that there are some statutory or corporate things which localities are not interested in. Pathways, which they are interested in, could be delegated down to localities. [Extract from fieldnotes, meeting ID M2]

This long extract from fieldnotes is included because it illustrates the issues which came into play in all of the merger decisions which we observed, including:

- The significant driver from the running costs assessment
- Some concern that they felt 'pushed' by both the PCT (and in some cases the SHA) rather than being enabled to make their own decision
- The importance of 'like-mindedness' between potential partners
- An intention to continue to delegate significant amounts of work to localities within the larger merged CCG

Three sites eventually agreed to merge with neighbouring groups. Two of these came to their merger rather reluctantly, but for the third site, the decision for two CCGs to merge was

voluntary and amicable. In this instance the decision was not based on size or on external pressure but was based on calculations about commissioning power with the local providers. This decision was greatly influenced by the local context in which discussions over hospital mergers were taking place. They realised that a unified commissioning structure would be in a strong position to negotiate with the emerging unified hospital Trust.

> So I think having one CCG is a better way to actually deal with the providers that are getting bigger and are coming together, and it gives you capacity, really, … [Manager ID 55]

We were told that this restructuring process has slowed this site's progress towards being ready to apply for authorisation but has also resulted in management cost savings. The smaller localities within the merged CCG expressed concern about retaining their local identity but recognised gains from being part of this large organisation:

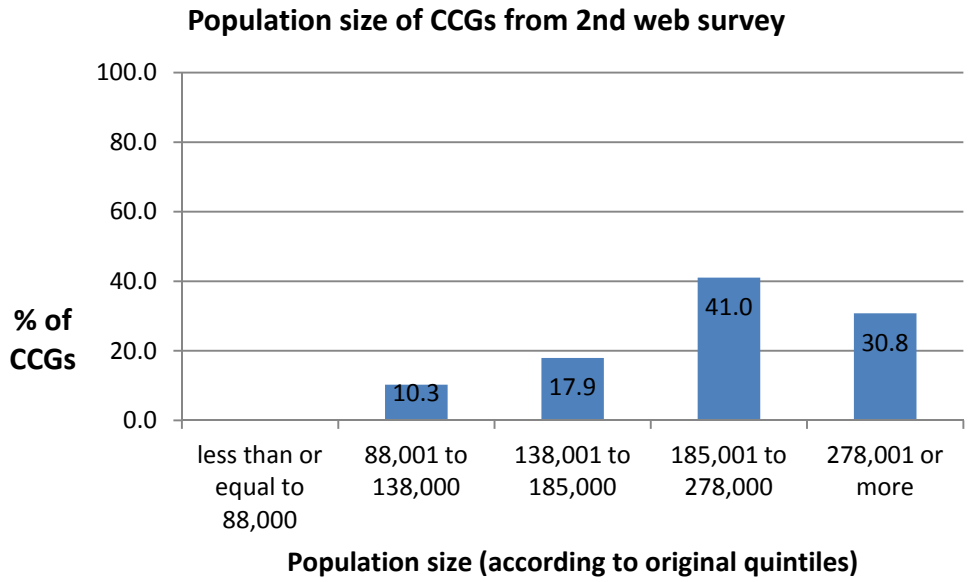
> In our locality, because we're so small …I don't think we've got the size to actually manage our own budget, that's why we need our CCG, you know, to absorb that risk. That's why we've merged as a [large] CCG, to mitigate those risks, and actually become bigger and absorb those fluctuations. (GP Locality Lead ID 67)

Thus, these three sites have all experienced CCG mergers but reasons for merging were slightly different: decisions to merge were all characterised by pragmatism but embraced with differing degrees of enthusiasm. Anxieties about the process were similar: there was concern that new large CCG may be remote from local groups and so could become an incarnation of former PCTs; and there was uncertainty about the role of local groups in relation to larger CCGs.

Two other sites, although also relatively small, decided to address the issue relating to running costs by sharing senior posts with a neighbouring group.

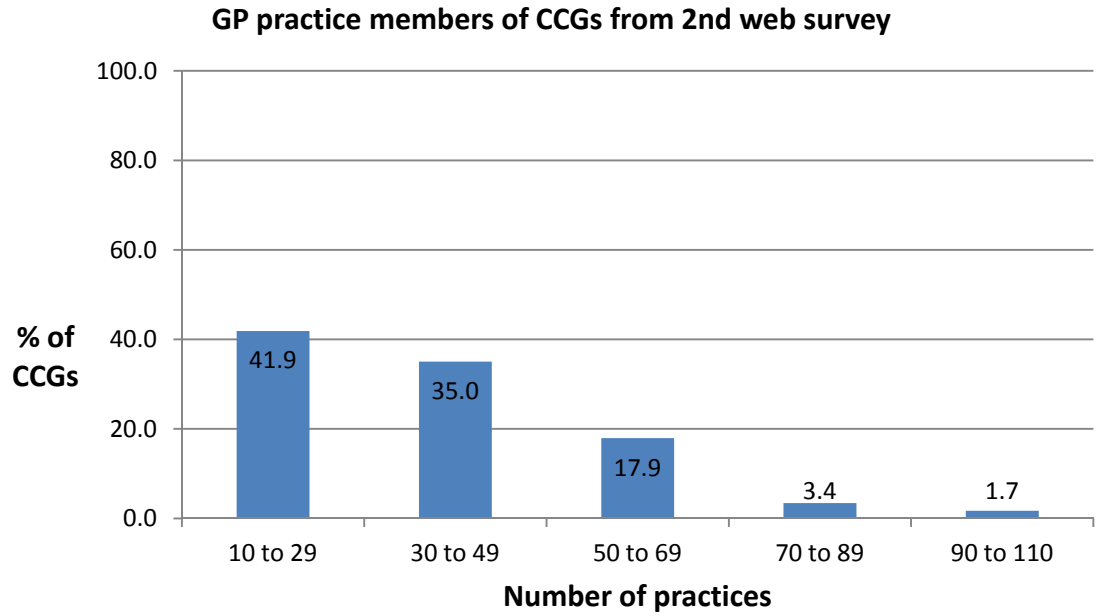
In the second web survey carried out in April/May 2012, 30 out of 117 (25%) CCGs reported that their configuration had changed since their initial Pathfinder application. Of these, 17 reported a merger, 6 reported that one or more practices had joined the CCG and 3 reported that one or more practices had left. One reported that a neighbouring small Pathfinder group had joined as a new locality within the larger CCG. In our initial sampling, we divided Pathfinder CCGs into quintiles, and (with the exception of the smallest quintile) sampled some case studies from each quintile. The figure below illustrates CCG sizes from of our second web survey in May 2012:

Figure 4: CCG size as at May 2012



As can be seen, the quintile of smallest CCGs (<88,000) has disappeared, and the others have shown a move towards significantly larger groups. The new median size is now 235,000 population, against a median from the web survey carried out in December 2011 of 176,000, and an initial median of 163,000 in July 2011. In terms of GP practice size, the new picture is shown in Figure 5:

Figure 5: Number of GP practices in CCGs as at May 2012



In terms of the SHA risk assessment process, three sites were rated 'amber' for one out of the four criteria (see above), and one was rated amber on all four criteria. The others were rated 'green' on all criteria. In general the concerns raised by SHAs related to:

- Crossing LA and other boundaries, with SHAs concerned to ensure that the groups had considered the issues raised by cross-boundary working
- Collaborations and mergers, with SHAs asking for clear statements about how joint working would be developed and managed over time

Those planning to cross boundaries devoted considerable effort to making the case for this, including obtaining written expressions of support from the Local Authorities concerned. Those planning to collaborate over posts also devoted time to finalising the details of how this would work. The 'rating' was a live issue in many sites over a period of several months, often referred to in meetings as the issues highlighted by the SHA were tackled.

Overall, this was a period of some difficulty in a number of our case study sites. The groups had formed initially based upon shared history and a desire to work together, and had started to think about how they might develop in the future. The official guidance at this stage was that CCGs were free to form themselves as they wished, and a number of our sites reported that they had had conversations at national meetings with senior policy makers who had reiterated their freedom to choose their own configuration if they felt that this was best for them. At the same time, the assessment of running costs was pushing them towards forming larger groups, and a number of sites reported to us that they had come under some pressure from both their local PCT Cluster and the SHA to merge:

> A: But there has been a tremendous amount of pressure to force us to merge and to form, to re-form the old PCT basically, which we are very reluctant to do.
> Q: Pressure from?
> A: Cluster, Strategic Health authority….other CCGs, individual managers and senior managers…..you just get let it be known that small PCTs would not be looked at kindly, small CCGs would not be looked kindly at.[GP ID 33]

Our findings suggest that there was an overall perception of 'constrained freedom', and some associated resentment in those sites affected. The mechanics of merger slowed the pace of development as the affected groups set about developing new ways of working.

Key findings: Risk and running costs assessments

- This was a difficult period for many groups
- Two groups felt themselves to be pushed towards mergers which were initially unwelcome
- The three case study sites involved with mergers expressed a strong desire to retain as many responsibilities as possible at locality level, but it is, as yet, unclear what this will mean in practice (see section 3.4.3)
- We were told that the merger process had retarded development in those areas affected
- The SHA-led risk assessment process was a potent driver of activity

3.1.4 Moving towards authorisation – developing structures and governance

In autumn 2011 and January 2012 more detailed DH guidance was issued about applying for authorisation and about governance arrangements. This was a time of rapid development

and change in all of our sites. Key concerns focused around the finalising of structures and processes whilst preparing for authorisation under each of the six specified domains.

Structures and governance

The guidance issued to aspiring CCGs with regards to structures and governance was relatively non-prescriptive. As specified in the Act, CCGs were told that they should have some sort of 'governing body' with at least one nurse member, a consultant member and two lay members. In addition it was specified that they should have an audit committee and a remuneration committee. Over and above this is it was left to CCGs to design their own structures, with the guidance posing a series of questions for CCGs to consider rather than providing a blueprint. It is difficult to discuss structures in a general way, as our study site CCGs have developed their own approaches, using names to describe committees/sub-groups that are not always directly comparable, with significant change over time. We have collected a large number of (often changing) organisational diagrams, and it remains difficult to make general inferences across such a wide range of different structures. In general, we have seen the following in our study sites:

- An over-arching '**Assurance**' body, planning to take over the statutory responsibility once authorisation is completed. Their primary activity is to receive reports from the 'operational' level and assure themselves that the work of the CCG is being undertaken satisfactorily. This group is usually called the 'governing body', and is the body which has the range of members specified in the Act and which meets in public on occasion. It has final decision-making powers, although these may be delegated to sub groups or committees. In smaller CCGs that we studied, formally constituted bodies at this level may also undertake some 'operational' activities themselves.
- A number of '**Operational'** bodies – the level at which the business of commissioning and the overall management of the group is conducted. This may include a number of different committees or workstreams. In addition, in some sites there is a formally constituted operational group of some kind containing a subset of the assurance level group, often called an 'executive', which undertakes the day to day management of the group's activities. In the smaller CCGs this responsibility is taken by the 'Assurance' body. Finally, some groups have informal teams of senior managers and/or GPs/other clinicians who meet more from time to time in order to carry out particular tasks or keep up to date with progress.
- A **'Council of Members' (CoM)**, consisting of representatives from each practice. Not all CCGs have such a body; some have practice representation via locality groups. Where it exists, this body meets regularly (monthly in some sites, quarterly in others) and the time is used to both inform practices what is happening and, in some of our sites, to gather opinions and seek guidance on the direction of travel of the group as a whole. The role of practices will be discussed in more detail in section 3.4.
- A number of **'Locality groups'**, consisting of smaller group of representatives from a geographical area within the CCG. In areas where mergers took place, the constituent CCGs became localities under the auspices of the new larger CCG. The role of these groups will be discussed in more detail in section 3.4
- A wider **Advisory group**. In two of our sites the CCG has convened a wider group of clinicians, managers and representatives from outside (eg the LA or the local provider trust) to provide advice about a range of issues. The role of these groups is still under development.

The potential complexity of governance arrangements is illustrated by this quote from one of our larger sites. They were keen to maintain significant GP and other local clinical representation within their structures, but were concerned about the size of group this would generate. The solution was to develop a multi-tiered governance structure:

> Well, because we're a large CCG, if we have everybody… so we have all of our locality chairs, and the two lay members, and the nurse representative, and the acute, um, clinician representative, all around a table, the meeting's going to be, ah, less than, um, efficient. So what I've done is created a proposal for two boards. One is the statutory board that… What do they call it? The governing body. And the other is more of a… It's still, to an extent, determining strategic priorities, but a subsidiary board. So you have the locality chairs on one subsidiary board comprised solely of GPs, you have a superior board - the oversight and governance board - comprised of some GP representatives from the lower board, and all those statutory appointees. [Manager, ID 60]

Initial governance structures depended to some extent on how the group had been constituted. In our interim feedback to stakeholders in December 2011 we stated the following:

Box 3: Extract from interim feedback

Early analysis suggested that it may be useful to loosely classify emerging CCGs according to their resemblance to previous institutions. These categories should be regarded as 'ideal types' which emerged inductively from early data analysis. Whilst case study CCGs did not all fit neatly into one category or another, early analysis suggests some differences in approach which may be partly explained by the category with which they have most features in common. The categories are:

- Replacing the Professional Executive Committee (PEC) of the PCT (referred to hereafter as 'PEC-type')
    - In two sites the new CCG board largely mirrors the old PEC, with much of the same membership and in at least one case the same chair. Additional members have been drafted in according to current guidance, but essentially the governing body of the CCG is very close to the old PEC. The PCT managers involved are of high level, often ex-PCT Directors and Chief Executives. In this scenario many of the GPs involved in the CCG were GPs with roles in the PCT such as PEC chair or Medical Director, although additional GPs have also joined. These two sites both have only one CCG with boundaries close to the old PCT boundaries, but other sites where there is only one CCG have not taken this approach.
- Building on Practice-based Commissioning (PBC) (referred to hereafter as 'PBC-type')
    - In three sites the new CCG board largely mirrors the old PBC group, with the addition of a few members such as lay members or nurses. The PCT managers involved with these groups (and assigned to the board as, for example, 'Chief Operating Officer) are in many cases ex-PBC managers rather than PCT Directors, although many of these types of groups also have PCT Directors 'aligned' to them to advise them. In this scenario the GPs are often the old PBC GPs, although in some cases new faces have joined as well, and may include ex-PEC members. Practice membership may also have marginally altered since PBC.
- More or less starting from scratch (referred to hereafter as 'new-type')
    - Three sites have started with what is effectively an entirely new organisational form, designed from scratch. In this scenario, although many individuals have been involved with commissioning or PBC in some capacity in the past, and some features of the new structure derive from previous PBC experience,

Over the subsequent five months we found some convergence between these categories. In one of the sites which had initially set themselves up as mirroring the PCT, a concerted effort

was made to adopt new and different ways of working, bringing in new GP leaders who had not been involved before and looking to combine some of their functions with the Local Authority. The other 'PCT-type' group took a different approach, regarding their resemblance to the old PCT as a significant strength. They explicitly see themselves as undergoing a 'seamless' transition from PCT to CCG, and seek to retain as much of the old structure as they can whilst also engaging local GPs and making it a clinically led system, with support from managers. Those who had initially built upon their previous PBC group have generally become more formal in their structure. Two of the three groups which took this approach merged with neighbouring CCGs, and the old PBC board became a Locality group within the new, larger CCG. The third of this type has taken the decision to set up an additional layer of governance at what we have called the 'Assurance level', meeting quarterly in public and containing the statutorily required members such as a nurse and a consultant. The old 'board' will become an operational executive. Those groups which set themselves up from scratch as new organisations have perhaps changed least, although there have been ongoing adjustments to organisational structures, with changing remits and membership of committees.

In terms of governance, a number of common issues and concerns have arisen across the case study sites. Firstly, there has been considerable discussion in all our case studies sites as to which responsibilities should lie at which level of the organisation. In particular, distinguishing between responsibility for governance/oversight and operational activity has been an ongoing concern throughout the research period. This is clearly illustrated in this extract from fieldnotes taken in an operational executive meeting fairly early in the process:

> Risk management
> Where should the detail of this be undertaken? Not yet agreed.
> Details should probably go to governance and audit group but members of the Executive also need to own it. Committee should receive papers and individuals go away and 'do the work' external to the committee.
> [Manager ID 152] said that there is a revised framework along with templates stored on the Shared drive but we need a mechanism for follow up
> It was agreed that there were too many and it was too operational for the Exec committee. [manager ID 114] agreed to revise the paper and set out the process more clearly..[Extract from fieldnotes Executive meeting October 2011 ID M3]

We have seen development over time, with emerging CCGs testing out different committee structures and making adjustments as particular approaches were found to be helpful or unhelpful. At present, there is an understandable concern in many of our sites that nothing should be missed, and as a result we have seen some duplication, with the same issues often discussed at each level within the organisation, and some lack of clarity as to where ultimate decision making responsibility lies. This GP expressed it thus:

> I think we have to define our board meetings a bit better; I think they go on too long; I think we have to work out what they're actually for. Are the board meetings for forming opinion or are they for making decisions or are they for both? And I don't think we know yet, really.[GP ID 68]

There is also a tension evident in all of our sites between learning from the previous experience of the PCT, whilst at the same time trying to build a new organisation that does things differently. One GP expressed it thus:

> [PCT manager] will go away and do the stuff and just present it to us, say this is what you've got to do. Um, I don't remember having a conversation

> about that. [Other PCT manager] is the same, they're still, they're still PCT people. They're trying to hang on, you know [GP ID 60]

On the other hand, from the perspective of those who had previously worked in PCTs, it was seen as obviously sensible to build upon what went before:

> And they're all things that have been dealt with before by, you know, the legacy PCT. So why are we reinventing the wheel? I don't understand that one at all. You've got to draw heavily. And if you do that, then you're going to get your governance arrangements right more quickly.[Ex-Non-executive director, ID 247]

Secondly, there is considerable complexity regarding the different accountabilities that CCGs will experience. Our case study participants are clear that becoming a CCG responsible for spending public money entails new responsibilities and a need for transparency, along with accountability to the general public:

> I described it to some of the CCG board members a while back, you're moving from being an owner/manager in a practice to a corporate director. …And it's that mindset shift, from being, 'well it's my business I'll run it as I like'. When it's £1.2 billion worth of public funds, you have to be a little bit more...accountable.[Manager, ID 60]

Some managers expressed concern to us that this would be a considerable change for many GPs, and that some might find daunting:

> I mean, I think our GPs are really quite well-informed about a lot of things, actually, but in terms of the real impact of what does it mean to be held accountable for this or for that… what, you know, is beginning to, sort of, um, scare people, to be honest, becoming quite… oh, my God, is that what that means, or something? How are we going to do that? [Manager ID 56]

However, in addition to this public accountability which is associated with being a statutory body, responsible for spending public money, CCGs are also membership organisations. The guidance on CCG governance issued in Feb 2012 (NHS Commissioning Board 2012e) underlines the need to develop structures and ways of working that ensure that member practices feel represented and engaged. Approaches to this varied considerably within our case study sites, with some seeing themselves as formally accountable to their membership, whilst others regarded the relationship as being one in which the leadership keeps the membership informed rather than seeking active engagement or being held to account. It remains unclear how this will play out in practice, and how any possible conflicts between these differing accountabilities will be resolved. This issue will be addressed further in section 3.4

Thirdly, concerns have arisen in many of our sites about demonstrating probity in organisations led by GPs, many of whom will have interests as providers. All of our case study sites are aware of these concerns, and some have spent a considerable amount of time considering how they will be addressed by, for example, running simulation exercises at board development days and making interest declarations at the beginning of each meeting. However, this remains an area of concern for many, with some disagreements between GPs and other participants about what constituted relevant or important conflicts of interest. For example, in one of the workshop sessions we observed, there was a heated discussion between a GP and a lay member (non-clinician) about how they should address a conflict of interest. In the workshop, they were asked to discuss a scenario where a GP Board member

has prior information about the tendering for a new practice. The lay member said that in his opinion it would be unfair and unethical for the GP to be taking part in the procurement. However, the GP replied that if they were to leave this particular GP out, they would have to leave every GP out because every GP has an opportunity to bid for the practice.

Some respondents expressed concern as to how conflicts of interest can be avoided when most governing bodies will have a (voting) majority of GPs. This was contrasted with the situation in PCTs, where the role of Non-executive Directors ensured that those making decisions could be properly challenged. We saw the following being put in place to try to deal with this issue:

- Declarations of interests at the start of meetings. Most often this simply consisted of the GPs saying 'we are all providers of primary care'
- Resignation of governing body members from provider roles. In one site, prior to the setting up of the CCGs some of the GPs involved had been members of a local GP provider group. They all resigned before taking up their positions. However, in another site most of the local GPs remain members of a local provider company, and they have not resigned from this
- Leaving the room when items discussed, or not commenting on them. This extract from fieldnotes illustrates this point:

  A service spec has been developed for an outcome based health improvement service with a single point of access service that incorporates for adults in [local area]. Proposed that tender process will begin in Dec 2011 with service commencement in June 2012. Service will be commissioned initially for 12 months with an option to extend for a further 2 years.
  [Nurse ID 20]- should the GPs go out of the room? Looks to GP ID1. Is a discussion about conflict of interests. [GP ID 7] is happy to go out of the room if people want. No objections and [GP ID 1] ensures that it is minuted that [GP ID 7] did not take part in any decision-making regarding this.
  [PH ID 11]- says how it is a fine line between engaging with service providers who can provide useful insight in designing a service spec and conflict of interest. It is agreed that GPs cannot comment on the service spec of anything if they are planning to bid for it.
  [GP ID 7] surely GPs have a conflict of interest with all community services? More discussion about COI point.
  [GP ID1] notes how it is a difficult subject in this time of evolving policy.

- By appointing more lay members to the board

In general, in all of our case study sites hope was expressed that behaving in a transparent way would help to alleviate these problems, but at the time of writing this report it remains unclear whether this will be enough in the longer term to avoid accusations of impropriety.

Key findings: Structures and governance

- Structures and governance remain areas in which rapid and ongoing development is occurring
- The authorisation process will entail aspirant CCGs developing clear plans on paper, with formal schemes of delegation and statements of the principles underpinning their operation, particularly in relation to conflicts of interest. Our case study sites recognise that there is also a longer term issue to be addressed to do with developing a governance culture in which probity and transparency become second nature
- CCGs have a greater range of accountabilities than their predecessor statutory bodies, with internal accountability to practice members, as well as accountability to the public and to the NHS Commissioning Board. Governance structures will need to reflect this
- We have identified the following key outstanding issues that need to be considered by developing CCGs:
    - What is the relationship between the 'assurance' level and the 'operational' level, and are both groups clear as to their responsibilities?
    - What is the relationship between the 'assurance' level and the wider GP membership?
    - Who is responsible for setting strategy?
    - What is devolved to what level within the organisation, and who can make decisions about which issues?
    - How much overlap in activity and responsibilities is there between the different organisational levels?
- Developing CCGs are aware of the issue of conflicts of interest relating to their interests as both providers and commissioners. In spite of some guidance on this issue, it is not yet clear exactly how these will be dealt with in practice, as many CCGs will have a majority of GPs on their governing bodies

Governing body membership: overall

Membership of the key governing bodies has changed and developed in all our case study sites over the period of the research. Early membership generally built upon what had gone before with, for example, those groups which had previously been PBC groups continuing initially with the same structure that they had had in the past. During the course of the study, some sites introduced changes. In general these involved the following:

- Bringing in new GP members
- Forming new governing bodies following mergers
- Bringing in Lay members
- Bringing in nurse or consultant members as required by the Health and Social Care Act
- Changes to Chair/Vice Chair

The governing body membership of our case study sites as at May 2012, is shown in Table 7

Table 7: Governing body membership as at May 2012

Site	Origin of group	No of GP members	**New/existing leaders?**	Lay members	Consultant member	Nurse member	Practice manager member
1	Largely New-type	6	6 existing	1 ex-NED 1 vacancy, currently out for open advert	N	N	N
2	Largely PBC-type	6	5 existing, 1 new	N	Y	N	N
3 (post-merger)	Largely PEC-type	13	12 existing, 1 new	N	N	N	N
4 (post-merger)	Largely PBC-type	5	5 existing	3 ex-NED	N	Y	Y
5 (post-merger)	Largely New-type	10	10 existing	1 ex-NED 1 ex-PCT Chair	2	N	N
6	Largely PBC-type	6	6 existing	Y (from local public involvement body)	N	Y	Y
7	Largely PEC-type	4	2 existing, 4 new	Y (ex-NED & LINk)	N	N	N
8	Largely New-type	5	4 existing, 1 new	1 ex-NED and one ex-senior NHS manager	Y	Y	N

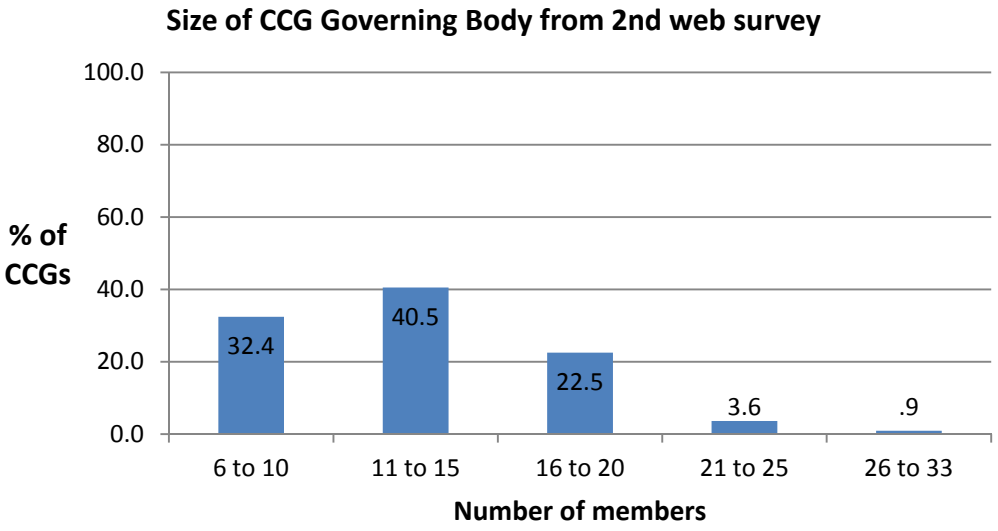
It is clear that these bodies are still under development, with consultant and nurse membership apparently most difficult. The consultant role in particular was felt to be problematic in a number of our sites, with only three out of our eight case study sites having appointed a consultant to their governing body. Most were reluctant to do so, telling us that they did not feel that the role was one which would add much value to what they were doing. Furthermore, there was some resentment that the role was being forced upon them:

> We now have the problem of defining this shoehorned in, secondary care role and this role, which as you say, we've had multiple discussions about how to define. And it created, I think, a sense of disquiet and uncertainty.[GP ID 283]

It would also seem that most CCGs are currently looking for those with current NHS expertise to provide their 'lay' membership, although one group has taken the step of issuing an open invitation in the press.

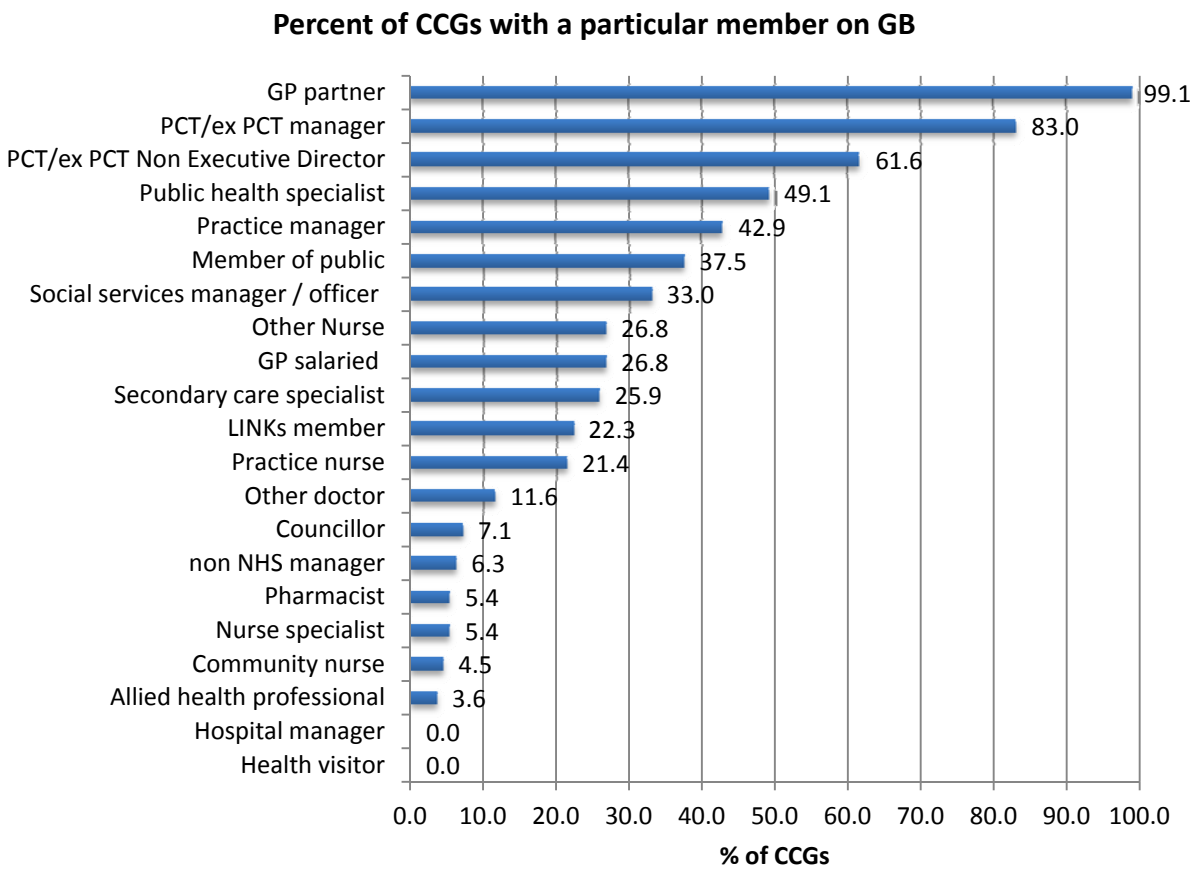
From the web survey in May 2012 we found that overall Governing Body size varied greatly:

Figure 6: Size of CCG Governing Bodies (N=118)



There was no clear relationship between size of Governing Body and size of CCG. In terms of Governing Body membership overall, we found the following:

Figure 7: Governing Body (GB) make up as at May 2012 (N=118)

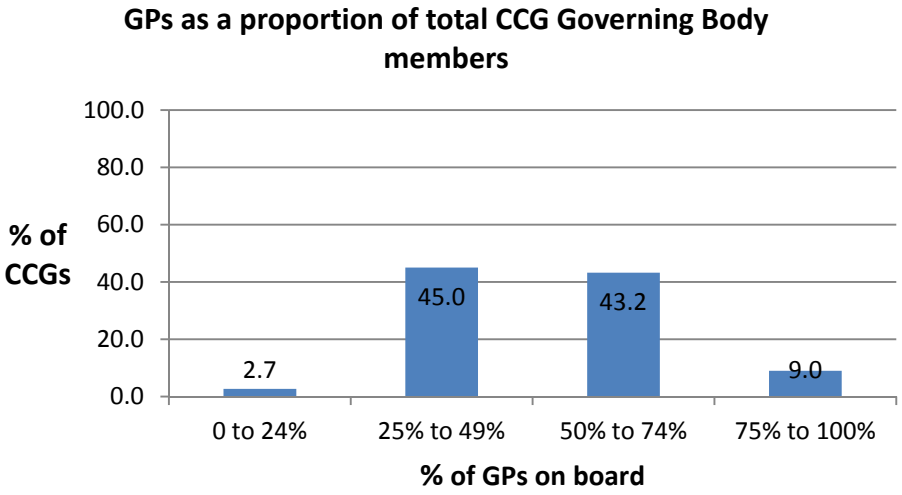


From this it can be seen that only 25.9% of the 118 CCGs in our sample had appointed a Secondary Care Consultant to their Governing Body. Whilst this role does not have to be in place until authorisation, CCGs have known for nearly a year that it was likely to be a requirement. The small proportion that have so far made this appointment suggests that the lack of enthusiasm about this role found in most of our case study sites may have wider resonance. 53.6% had appointed some sort of nurse, with 21.4% choosing a practice nurse for this role. In addition, 22.3% have appointed a LINks member, and 61,6% an ex-PCT Non Executive Director. Only a very small number have appointed members of other professional groups such as Pharmacists or Allied Health Professionals, both of which had roles in PCTs. Just over a quarter (26.8%) have representation from a salaried GP.

Governing body membership: GPs

From the survey results, we calculated the percentage of Governing Body members who were GPs:

Figure 8: GPs as a percentage of total CCG Governing Body members (N=118)



Thus, 52% of those responding to the survey report that their Governing Body contains a majority of GPs. However, the survey did not distinguish between voting and non-voting Governing Body members; it is therefore highly likely that many of those listed as Governing Body 'members' may be non-voting members. Certainly, in our case study sites most Governing Bodies had a number of members such as Local Authority representatives or Public Health representatives who had no voting rights. It therefore seems likely that most Governing Bodies will have a majority of GPs as voting members.

Most GPs involved as Governing Body members in our case study sites have had previous leadership roles (see Table 7). The exception to this was Site 7, where they made a concerted and successful effort to reach out and recruit new faces. This manager explained what a difficult task faced those becoming involved for the first time:

> We're asking the GPs now because they haven't been involved to make a huge intellectual leap very, very quickly. And it is quick to get them in a position to be in authorisation of accountable budget holders... accountable budget holders, and accountable for the decisions, therefore, they make, not just on patient safety quality, but also on the money; a huge, huge cultural change. And, again, how many of them ultimately will be up to it, who will want to be? I don't know. [Manager, ID 2]

This manager from the same site explained how valuable the new GPs could be:

> The new GPs who've stepped up are actually... have been really, really good and have actually added something really new. I think what you needed in a way was someone who was a brand new, fresh approach to it saying this is the new world, it isn't just a... the old PCT with more GPs on it, it's a brand new world, this is GPs taking charge, let's... come on, let's get involved and throw some enthusiasm on it, which is actually really, really good. [Manager, ID 3]

This GP explained his motivation for getting involved:

> I think I've become a bit bored with general practice, and quite worn out because of the, I was doing, well, eight clinical sessions and one teaching

> session. I was very, very full time. And I think I was just getting a bit jaded by it. And so this has been a real reinvigoration.[GP ID 8]

However, other sites were less successful in recruiting new leaders. One site had a GP vacancy on their governing body throughout the data collection period, some CCGs didn't hold elections due to a lack of volunteers to stand and several GPs described their selection as being 'by default':

> Q and how were you, ah, elected as a locality lead?
> A: Well, it was quite a while [ago]… it was during PBC times. Um, a retired GP, did it before me and it sort of… you know, they sort of said, oh, [name], you'll do it, won't you, sort of thing. And I had a moderate interest and, you know, it was a sort of, everyone stepped back and left me standing out at the front, um, so I took it on. [GP ID 68]

Some GPs had been involved with PBC for some time, and described their CCG involvement as a continuation of that work, whilst others had been involved in previous administrative groupings and were returning to a leadership role after some time away:

> Well, interesting, [GP ID 104] had done it with it was a PCG.I don't know if he was chair of whatever would have been out there, but, he…there was a type of GP, to me, who loved PCG's. Who, then, just didn't see it when the PCT's were set up, they just didn't want to play ball. …and some of them are coming back into the tent, so, [GP ID 104] did do it before. [Manager, ID 114]

Data obtained from the telephone interviews confirms the dominance in emerging CCGs of those with previous experience in leadership roles. Out of 33 respondents answering a question on this topic, 19 told us that all of the GPs active in their CCG had had previous leadership experience, whilst 14 told us that their CCG governing body included one or two new GPs alongside more experienced leaders. Previous roles included being PBC leaders, PEC members and PCG members, with a few also having had roles in other bodies such as Out of Hours Co-operatives and LMCs..

It is clear that enthusing and engaging new GP leaders will be crucial to the longer term progress of CCGs. This manager in one case study site expressed concern over the longer term involvement of GPs and the dependence on a few enthusiasts:

> I'm still unsure of the long term involvement of GPs in this whole thing, because I do feel, you know, I think GPs, you know, the issue around GPs, you have an initial enthusiasm from the GPs. You've seen our GPs round the table; I don't see any succession planning, or that much succession planning – I don't blame anyone for it – but if Chair, tomorrow said, 'I'm bored, I've had enough of this', I haven't got a clue who would step into that role. And if at the end of say two years, [GP ID 102] said, 'my practice needs me back', or [GP ID 104], I don't know who would do it… I'm still not sure whether long term, GPs will be able to maintain their enthusiasm. [Manager ID 116]

The one case study site which was successful in bringing forward a significant number of new GP leaders did so by engaging a wider group of GPs in a forum which focused specifically on local clinical issues. This was then successfully used as a recruiting ground for new Governing Body members. This could be a model which other CCGs might be able follow. Some sites have indicated that they intend to require GP members to seek re-election on a regular basis (eg every three years), with one site intending to stipulate a maximum of two terms of three years, suggesting that the continued engagement of new GPs will be

necessary in the longer term. Furthermore, re-election would probably need to be on a rolling basis to ensure sufficient continuity to allow business to continue. This is a particular issue given that most groups would appear to be setting themselves up to have a GP majority.

Governing Body membership: gender

It is clear from both our case study sites and our survey that there is a potential issue in relation to the gender of Governing Body members. Experience in the case studies alerted the research team to this issue, leading to the inclusion of a question in the second web survey asking respondents to specify the gender of Governing Body members. We found that, in total, 514 out of 1452 (35.4%) Governing Body members are female in those responding to the survey. However, this includes managers, of whom 151/217 (51.5%) are women. If GP Governing Body members alone are considered, only 146 out of 721 (20.2%) GP Governing Body members are women. In terms of total female GP representation, 28 out of 110 (25.5%) respondents to the survey report that they have no female GPs at all, and 45 out of 110 (40.9%) Governing Bodies contain only 1 female GP. This is against a total general practice workforce in which 50% of GPs are women (source: NHS Information Centre). This suggests that female GPs are currently seriously under-represented on developing CCG Governing Bodies.

In order to explore this issue further, we asked our telephone interviewees about the representation of women on their Governing Body. As at the beginning of July we had carried out 38 telephone interviews. Only 5 of these had representation of more than one or two female GPs, and some had none. Fourteen interviewees said that they were unhappy with the gender balance on their Governing Body, and five told us that, although they had few/no female GPs, they did not regard this as a problem. In 4 cases this was said to be because they had good representation of female managers, which compensated for the lack of female GPs. One interviewee simply did not see that it was an issue at all:

> I think a lot of our lady doctors want to just be nice to patients and be allowed to get on and do their job that they trained for, rather than having ambitions to erm, to get involved in sorting the system out... there's a need for both [telephone interviewee ID 1]

Those who agreed it was an issue were asked to explain why they thought it had occurred. In general, the appointment procedure followed had been to advertise the roles, asking prospective members to put themselves forward for election or selection. None of the groups had undertaken any kind of positive discrimination or done anything to try to generate a gender (or ethnic) balance. Possible explanations were offered by a small number of respondents, and included::

- Female GPs are more likely to have family commitments 4/20
- The roles are very demanding and ‘not attractive enough’ 4/20
- Female GPs don’t like putting themselves forward 1/20

Suggested remedies included:

- Greater clarity about what the roles involve
- Better remuneration and support structure for those taking on the roles
- Working with the LMC to identify likely candidates
- Encouraging women to take on lower level ‘development’ roles, stepping up to a Governing Body role later.

We recognise that these are small numbers, but they give some indicator of issues that need further follow up in later research.

Key findings: Governing body membership

- Many CCGs have struggled to bring in new GP leaders, with Governing Body and leadership positions largely occupied by GPs who have held such positions in the past. Encouraging new GPs to come forward will be key for the future success of CCGs. Some CCGs have suggested that governing body members will be required to step down after 2-3 years. If this ends up being the case, we believe that there will be an even more urgent need to recruit new GP leaders
- Board size is very variable, and is not related to CCG total size
- The requirements to appoint a nurse and a hospital consultant to Governing bodies have not been universally welcomed, and many have not yet appointed these members
- There is an emerging issue with the gender balance of CCG Governing Bodies, particularly relating to the involvement of female GPs
- Few Governing Bodies have representation from other groups such as Allied Health Professionals or Pharmacists

Personal and organisational development

In all of our case study sites, some process of formal organisational development has taken place, alongside personal development for GPs and managers. Overall, the particular areas addressed in this process were in part the result of some kind of formal needs assessment process, and in part based upon the availability of particular training sessions.

Table 8: Organisational and personal development

Site	Organisational development	Personal development
Site 1	Development sessions for governing body and for GP membership facilitated by SHA and PCT Cluster	Governing body members provided with personal mentorship by a PCT Cluster manager
Site 2	Development sessions for governing body and GP membership facilitated by external consultants	Senior level personal coaching provided both internally and by outside agencies. Ongoing series of personal development workshops
Site 3	In house development sessions facilitated by PCT Cluster	Governing body members provided with personal coaching by PCT Cluster, and GP membership invited to educational sessions about commissioning
Site 4	Development sessions for governing body facilitated by external consultants	Governing body members provided with personal development support by PCT Cluster, and expected to complete a number of e-learning modules
Site 5	Development sessions for governing body facilitated by external consultants	No formal personal development training for governing board members. Individuals have been able to avail themselves of 'one off' training opportunities
Site 6	Development sessions for governing body facilitated by SHA	Governing body members able to attend local 'leadership training' provided by PCT Cluster
Site 7	Development sessions for governing body and GP membership facilitated by external consultants	Governing body members and GP membership provided with personal development support by external consultants, including opportunity to attend training sessions on commissioning
Site 8	Developmental sessions for governing body every other month, facilitated by a variety of training providers	Governing body members able to attend a variety of training sessions and all undertaken a formal development programme

GPs taking formal roles within the CCGs were aware of their need to develop their skills and expand their knowledge, particularly in the area of finance and governance, and they welcomed the personal development support they had been offered. Development sessions were generally welcomed, although at least one session (facilitated by an external consultant) observed by a researcher was felt by CCG members who attended to have been unhelpful. Those sessions involving some kind of practical exercises working on difficult decisions were felt by attendees to have been particularly helpful. For example, in Site 1 a session was held in which the governing body worked on a number of simulation exercises relating to conflicts of interest. These were said to have been helpful. This type of work was largely funded by the £2/head of population provided to each CCG for their development. However, concerns were expressed in some sites over the costs of this to the NHS as whole.

Key findings: Personal and organisational development

- All of our case study sites have had considerable personal and organisational development opportunities from a variety of providers, including external consultants
- The training and development provided was based upon a combination of formal assessment of needs and the availability of training from providers
- Some concerns were expressed over the costs of this work to the NHS as a whole

3.1.5 Moving towards authorisation: management and commissioning support

In the early stages following publication of the draft Health and Social Care Bill, PCT Clusters were encouraged to begin shaping their commissioning support staff into a standalone organisation that would contract with local CCGs to provide support. In early 2012 guidance was issued which stated that these Commissioning Support Services (CSS) organisations would be 'hosted' by the NHS Commissioning Board until 2016, and set out a timetable for their development, including 'checkpoints' to ensure they were viable. The size and scope varied across England, from a model adopted by NHS North of a very large CSS with local teams, to individual PCT clusters which decided to set up their own CSS. Over the period of this research, the developing relationship with the CSS was a key issue for all of our case study sites. This section of the report will focus upon the wider issues that arose consistently across sites.

<u>In house employment of staff</u>

In the second survey (May 2012) CCGs were asked if they intended to employ personnel directly. Almost all (90.4%, 104/115) said that they did. In addition they were asked if they intended to share any posts with other organisations locally – seven in ten (69.9%, 79) said yes, only five (4.4%) said no and a quarter (25.7%, 29) were undecided / didn't know. In addition eight in ten (93, 82.3%) of CCGs stated they intended to buy in services such as IT, HR or other commissioning support. It was notable that 13.3% (15) CCGs at this stage were still unsure.

Four of our sites initially intended to do as much of the managerial and commissioning support work in house as they could:

> ..part, part of the reason why we still haven't worked all this out yet, is because we thought that as a large CCG we'd be doing a lot of this in-house anyway, so it came to us fairly late in the day that we would have to start thinking about externalisation of, of a lot of this.[Manager, ID 171]

> I think our feeling is to try and keep as much in-house, but recognising that a lot of that isn't affordable. So actually, what can we share? [GP ID 7]

There were two reasons given for this. The first was that they wanted to continue working with the trusted managers that they had worked with for some time:

> Nobody in [local area] really dissented to the view that we wanted those managers that we trusted to be alongside us.[GP ID 61]

Secondly, it was felt to be important that those working on the commissioning support should have a good knowledge of the local area:

> I think there's certainly a scope for sharing commissioning support with our local CCG's so we don't lose the local knowledge and local intelligence. We've got some good staff at the PCT, we don't want to lose them and so I know the push from on high is sort of, you know, buy it in from a large regional, national organisation but actually it's not always cheaper to do it that way. I mean you end up, if it's too remote, you end up reinventing it within your locality because you don't trust the organisations providing [it]. [GP ID 282]

However, over time it became clear that with the resources available (£25/head) it would not be viable for all but the largest CCGs to keep commissioning support in house. There then followed discussions in all our sites as to where they should obtain the support that they would not be able to employ in house. Two sites were keen to share commissioning functions with their local authority:

> We've got a viable [Cluster-based] commissioning support organisation which will do high-level acute contracting, and we've got a Local Authority team which will do, I think, out-of-hospital, much more the out-of-hospital piece joined up with the [social care][GP ID 1]

However, whilst one site carried on planning to work in this way, the other believed that this would not be allowed:

> Yes, I mean, we did original work in October time, this is at the start of the organisational design….and worked our way through all the commissioning cycles and said what have we got to do, because it's about relationships and local knowledge, and what could we farm out.....And where we came up with things and we said right, what kind of partner would we want to deliver this with, the logical answer for us was the local authority…. so we kind of knew in October, November what we were doing…..[but]the national rules don't allow for that. We have to go with the commissioning support service.[Manager ID 173]

Others decided to share posts with their neighbouring CCGs. For some this mainly involved the senior managerial positions within the CCG such as finance. Others intended to share commissioning support functions as well:

> People, some people from the PCT, so some functions that the PCT was doing, we can't do it at the CCG level because it's too expensive, at £25 per head, to do it. …So we can either buy it as a CCG or we can buy it as a federation, which may, which is why the federation is in place, to get better value for money so… And these functions are something like mental health commissioning, children's commissioning, contract and procurement, things of that sort that you don't need it, it's too expensive to run within the CCG at this, at 120,000 or even that…You need to be at least five, 600,000 to be making it cost-effective [GP ID 35]

<u>Developing CSS: concerns and issues</u>

Most of our sites were planning to work mainly with their local developing Commissioning Support Service, but some expressed dissatisfaction with what was on offer locally. At least one entered into discussions with a CSS outside the PCT Cluster area:

> About the CSS, [manager, ID 169] said that he had had an informal discussion with the Local CSS, this had been an introductory meeting. They

> are happy and interested to keep talking and they need to know what we want. Other possibilities are CSS in [a number of neighbouring areas]- they need to have conversations with these CSS. If Local CSS don't come up with the best offer, they need to have a fall back position; [two neighbouring CSS] are possibilities. [GP ID 161] had asked "if no one buys their services what happens to them?" he had been told that "no CSS will fail". [laughter round the room]. [Extract from fieldnotes Executive meeting February 2012 M5]

However, there was some confusion as to whether they were allowed to contract with non-local CSS units. Whilst nationally they were being encouraged to choose the support that they wanted, some SHAs appeared to be pushing CCGs to work with the local unit:

> Well, er, again, this is difficult: the GPs want to take an open view of this and say they want to see the offers from a range of commissioning support services and be able to then choose the one that determines the most. Quite rightly what the SHA are saying is, no, we need some stability in some, um, of a, a period of, um, a period for the CSSs to get up and running and be able to establish themselves effectively, so they need a period of at least, um, 12 months, possibly three years, where they have guaranteed business in order to get themselves going [Manager ID 171].

One of the problems articulated in a number of sites was the fact that CCGs were being asked to make some kind of initial commitment to their local CSS in order to allow that organisation to pass its initial organisational 'checkpoints', whilst it was still unclear whether the support that was on offer was what they wanted or was of appropriate quality. Eventually pragmatic decisions were made:

> [Manager ID 170] explained that [Local] CSS had now made a formal offer. The offer is not too bad but further detail needs to be added. The core offer is here.
> [manager ID 170] is to work several days a week from now with the developing CSS issues. There will be a SLA in place for a nominal contract – the CSS had originally asked the CCG to sign up to a 4 year contract but this was turned down (as no detail is known) but the CCG agreed to work with them as they develop. Decided best to work on a geographical area (consolidate footprint) as neither the CSS nor the CCG is yet mature enough to pick from any other alternatives. [Extract from fieldnotes, Executive meeting February 2012 M5]

There were also a number of concerns expressed over the size of developing CSS. There were three elements to this. Firstly, there was concern that if the CSS was very large and covered a large geographical area there would be insufficient local knowledge and that existing strong local relationships would be disrupted:

> [Local authority commissioner]: If the NHS retreats into a large CSS the local level mustn't be torn apart. [Local authority member] said that there was disquiet across the area in adult services and children's services about this and they were putting together a response. …Manager ID 244] said that he thought that it could be done although he added that this was being done in order to follow a national directive, he said that locally speaking, they wouldn't have decided to go down this route. He added that national directives are unclear but that they are currently thinking about [neighbouring CCGs] jointly seeking the services of the CSS. He said that the good news

> is that locally they have good relationships. ….[Local authority members] reminded everyone that they have to navigate the way that is best for local people. [GP ID 239] said that they were jealous of localism and that the pressures from the local environment were very big. He said that they were committed to working together.[Extract from fieldnotes, H&WB meeting March 2012 M7]

The interviewee below made a distinction between those elements that could reasonably be provided centrally, and those which needed more local knowledge and a more local focus:

> So, for me, the really core work for us is relational. In terms of transactional work, I think that can be done by a CSU quite easily….. for me, the design of pathways is fairly transactional, I think. It's about getting the national guidance and working out what expectations we should have. The trick for us, as I say, locally, is the interpretation of that. So pathway design, I think, can happen elsewhere. I think, and I think I'm in a minority of one on this, that a lot of the financing, contracting, kind of analytical support, can come from elsewhere. I think we need our own contracting team, small contracting team, to work with us to make sure we get the right agreements and so on, but in terms of the analysis of what's going and so on, I think you get a much better on a bigger scale….[Manager ID 204]

Others were concerned about the loss of close personal relationships and the need for more formality:

> it's going to become more and more difficult, it's going to be more and more lengthy to get things done, I think. Because you don't have that shorthand. [you can't just pick up a phone and say] 'Hi, so and so, you know you did that?' 'Can I have a word' You know? It's not going to be like that, it's going to be fill in a form, or you speak to somebody you might even never have met. And you know? So I think that might be…more difficult…I think so, yes.[Manager ID 122]

Secondly, there were concerns in some sites that very large Commissioning Support Services might have their own agenda, which may not reflect the needs of a small CCG. Finally, there was a concern that if CSSs were large, the CCG would have to devote resources to checking the work that was being done on their behalf:

> I think we had originally thought of a very small core team of twelve to twenty people. We've just had a meeting today about quality assurance. You have to know that what you're getting from any commissioning support organisation is robust and correct. So that you end up pulling a whole bunch of people to check what they're doing is the right thing, or do you just employ the people and check them yourself? I think we're struggling a bit with that at the moment, because we don't know precisely what the CSS are going to offer and what quality assurances they'll be able to offer us. [GP ID 283]

However, in spite of these concerns, some could see some advantages to a large CSS:

> I think there's real opportunities with the CSS to do things that we haven't done very well, like education of primary care. ….. And I think there's a real opportunity with the CSSs, to do that on a kind of industrial scale, for the whole of[the area], in a way that we just…you know, if there was a team for the [region], to do that for us, they could get a massive economy of scale and really help us work to do those kind of things. So, it's some of the things that

> we haven't done very well and I think we could do much better with CSS. [Manager ID 204]

Developing CSS: impact on staff

There was general agreement across all of our sites that, as one might expect with a reorganisation this size, the process had been disruptive and very difficult for the staff involved. Some sites had lost important PCT staff members, and others described a degree of 'churn' which was felt to have the potential to impact on their work:

> But I also think that going forward, we're going to struggle, I think, to achieve what we want to achieve, not least because people seem to be moving on. It seems to be in a permanent state of flux, the Commissioning Support Service. [Manager] came in, she appeared, from my perspective, to look as if she was really good, seemed to know what she was doing, organising things, there seemed to be quite a good solid organisation, and I thought, 'They're going to be fine.' And then, she's off now, to wherever, and they've got an interim person, for six months or whatever and it's just…and people are leaving, and people are going off on secondment it's just all a bit…and you're beginning to wonder, 'Actually is there going to be anybody there to do what we want them to do?'[Manager ID 122]

Others described the significant demotivation experienced by some staff:

> Because this thing called commissioning support has taken so long to evolve, that you've still got staff completely unsettled. I get a bit fed up when people say, 'well they've got a job', because I don't remember, I'm a qualified accountant, and it was a part of my studies, that I don't remember staff motivation of, 'make people feel unsettled, tell them at least you've got a job, and get on with it'. I don't remember that chapter in my book.[Manager ID 166]

Overall, it was the middle grade staff in our case study sites who told us that they have found this most difficult. For some more senior staff, who have had a role in shaping the direction of travel of the group, the uncertainty was offset by their sense of job satisfaction:

> And, at the time, it was quite an uncomfortable time, I think, for a lot of people, although, you know, when I describe, you know, how we're operating now, it was, clearly, for the best and things have steadily got better as, you know, relationships and governance has, sort of, developed. .and it was quite uncomfortable, at the time, but…it's been [personally] great, to be honest. [Manager ID 115]

However, some of the more senior staff also expressed their deep commitment to the NHS, and to public service, and told us that they were concerned about a future in which some functions were taken on by the private sector:

> And, I struggle, because, I didn't come into the public sector to do most of my business with the private sector….I'd have had a private sector career, if I'd wanted that. So, I do struggle with that.[Manager ID 114]

There were also concerns in a number of sites about the negative impact of the uncertainty on the delivery of current programmes.

> [Manager ID 166]: We need to have standardized contracts (NHS style) for all contracts by end of summer- this will be very challenging for the CSS to complete. They aren't managing to keep things going while they are putting their systems in place. [staff member] due to meet with CSS later and will raise this issue and concerns.[Extract from fieldnotes executive meeting March 2012 M9]

Whilst the quotes given above mostly came from managers, many of whom were directly affected by the uncertainty, these concerns were not limited to managerial staff. GPs also told us that they had found the process difficult, and that they were concerned about losing the skills of managers whom they had worked with for many years. They were also concerned about the loss of personal relationships consequent upon the concentration of commissioning support in larger organisations.

Key findings: Commissioning support services development

- The movement of Commissioning Support from the PCT Cluster into a new, standalone organisation has been difficult in all our sites
- Four out of the eight case study sites started off in October keen to employ as many staff as possible in house, but had to change these plans in response to the proposed running costs allowance.
- CCGs have concerns about the size of the developing CSS and are anxious to retain both trusted staff and a local focus
- Some participants could see potential advantages to a large CSS, including economies of scale and the ability to share best practice
- Both GPs and managers have found the transition difficult, as CCGs have been asked to sign initial agreements with organisations which are not yet fully formed and whose capabilities they are not yet sure of
- Some of the problems have arisen due to a lack of specific guidance, with, for example, confusion over the rules relating to CSS/CCG agreements, in particular whether they are obliged to sign up with their local CSS or not
- There has been considerable disruption and uncertainty for middle grade commissioning staff, but more senior staff who have had the opportunity to shape developments have found the process less difficult.

3.1.6 Moving towards authorisation: senior leader recruitment

Towards the end of the data collection period, CCGs were working upon the selection and nomination of senior leaders for the group, including an Accountable officer, Chair and Chief Finance Officer. The process to be followed in this was first set out in a letter from Dame Barbara Hakin (2012). In sites 2,3,5,7 and 8 the nominated Chair is a GP and the nominated Accountable Officer (AO) is a manager. At the outset one of the Sites wanted to go straight to open recruitment but was told by the SHA to look at existing managers in the first instance. All of those managers nominated for the AO post have previously been employed at PCT Director level. Sites 1 and 4 have decided to nominate a GP to be AO, and have nominated an ex-PCT Non-executive Director as Chair. These sites have also appointed a GP as Vice Chair. Site 6 has nominated a GP as Chair but is yet to decide who they wish to nominate for AO. Apart from Site 6, those sites which have nominated a manager for the AO post have opted to nominate the trusted senior manager who has been working with them from the beginning of the process. Some bewilderment was expressed in meetings when it was suggested that this post should be put out to open competition, as CCG governing body members were generally very committed to retaining their current senior manager in position, and the flow chart sent out in May 2012 explaining the process was said to be confusing and

difficult to follow. Some told us that they found the idea of the Assessment Centre process rather daunting. Others were dispirited by the whole process, feeling that they wished to make their own decisions about their leaders:

> [GP ID 33]: there is a national pool of AOs and chairs now. We have to nominate someone for national pool. We've already got a chair – why do we need to go through this?
> [GP ID 35]: It's an assessment framework
> [GP ID 33]: It's absurd. It's got a flavour of top down rather than bottom up. I look forward to wasting lots of time being told what I already know. Are we dispirited? Yes. A bit. Such a waste of bureaucratic time.
> [GP ID 35]: Glad you said that and not me! You and [manager ID 43] are in it together (ID 43 nominated for chief finance officer pool).
> [Manager ID 43]: I have some flow charts if you want to see the process?
> [GP ID 33]: Hm, how I love being told to retrain after years of chairmanship.[Extract from fieldnotes, Executive meeting March 2012 M10]

More recently, GP ID 33 (above) who was the Chair of the CCG, has stepped down from the process having become disillusioned.

From the second web survey carried out in May 2012 we know that:

- 100 out of 107 (93.5%) CCGs replying to the survey had nominated a preferred Accountable Officer to go through the assessment process
- Of these, 33 (28%) had nominated a GP for this position, and 74 (72%) had nominated a manager
- 103 out of 108 (95.4%) CCGs replying to the survey have nominated a preferred Chair to go through the assessment process
- Of these, 98 (90%) had nominated a GP, 2 had nominated another health care professional whilst 9 had nominated a lay person (8%).

This suggests that there will be a number of CCGs with a GP as both AO and Chair. Guidance suggests that if this is the case, then there must be a non-clinical Vice Chair who can take over the chair should there be any conflicts of interest at stake.

Key findings: Senior leader recruitment

- Most CCGs have nominated a preferred Accountable officer and a Chair
- There is little appetite for open recruitment for these posts, with CCGs preferring to build upon the relationships and trust built up during the developmental stage and appoint those currently working with them to the senior posts
- Guidance on this issue was found by some to be confusing, and the late issuing of the Human Relations guidance relating to staff appointments (in May 2012) was felt to have been a problem

3.1.7 The authorisation process – experiences and approaches

CCGs were aware from early 2011 that they would need to go through some sort of authorisation process, with the formal 'authorisation domains' (developed with CCG input) published in October 2011. Over the nine month data collection period a considerable amount of time was spent in each of our case study sites preparing for this process. It is possible to characterise the approaches taken across the eight sites as being on a continuum. At one end of the spectrum the process in two sites was clearly owned and run

by the GPs, addressed and worked on in meetings. At the other extreme, authorisation in two other sites was tackled largely by managers working in the background, reporting at intervals to the wider group with much less active GP involvement. The remaining sites fall between these two extremes. Mechanisms and processes adopted to develop the evidence needed for authorisation included:

- The establishment of 'working parties' to focus on each domain
- The use of external consultants to support the process
- The use of the published 'self-assessment' tool to benchmark progress. In a number of sites this tool was used regularly as a means of plotting progress as well as identifying gaps, and in at least one site its use was extended to GP practice members in order to ensure that they were engaged with the process
- Formal and informal discussions with the local SHA Cluster
- Board to board discussions with the PCT cluster to discuss progress

All of our sites commented on the amount of work required in a short time. This comment was typical:

> ..last Friday, we had to do a submission with a load of documents and when we will have everything else. This week, there's another submission. It's a massive, massive process which it should be because you're creating a statutory organisation, but it's a phenomenally exhaustive process about what you have to have in place before they'll approve you to go. [Manager ID 173]

There were some concerns expressed in a few sites that the energy expended on applying for authorisation had reduced the focus on other aspects of their work:

> And I think that since we've been looking much more towards CCG authorisation, CCGs coming together I think that those, that QIPP agenda has dropped off the board, erm, papers, really.[GP ID 61]

Some of those who had previously worked in PCTs characterised the process as being very similar to that which they had experienced under the old World Class Commissioning framework:

> [Manager ID 288] explained that there are 4 waves of application and 6 weeks before application they need to submit 40-50 names for 360° survey. This is being undertaken by [manager ID 302]. There will be a whole day session where a team will come and question the Board like they did for Board to Board with the PCT Cluster.
> [ex-NED ID 295] commented that World Class Commissioning is 'well and alive'. [Extract from fieldnotes Governing body meeting April 2012 M12]

Respondents pointed to a number of elements of the support on offer that had been particularly helpful. These included:

- Clear guidance documents relating to the authorisation process
- The interactive self-assessment tool
- Support from the SHA Cluster, both in terms of running workshops and events and in sending representatives to CCG meetings to discuss the issues
- Board to board discussions with the local PCT Cluster

These were confirmed in our observations. In particular, in two sites we saw the self-assessment tool being used as an important live document, revisited over and over as

development progressed, with earlier iteration saved in order to allow them to show development as part of their authorisation assessment. Others found it less useful:

> I mean, the toolkit they provided for us to fill in how we feel it's going for us was really only marginally relevant to what we're doing [locally]. She said that the toolkit itself was poor but you fill it in and then, three or four weeks later, you have a meeting about it and at the meeting, it's discovered that, actually, the toolkit didn't really reflect what was going on at all. Well, I could have told you that when we first filled it in.[GP ID 33]

In addition, we observed a number of board-to-board meetings which were felt to be developmentally useful both in affirming progress and in pointing to areas that needed further work, although some GPs told us that they initially found these meetings 'nerve-wracking'. The value of SHA Cluster workshops was expressed in this meeting;

> Authorisation event [Local SHA Cluster] Some good information provided and good to see David Nicholson and Barbara Hakin there. Helpful in terms of 'myth and legend busting'.[Extract from fieldnotes Executive meeting December 2011 M11]

This was a pattern found throughout the study – those who attended meetings at which national leaders appeared welcomed the information that they received. However, it could also cause confusion, as on occasion other bodies such as SHA Clusters gave guidance which contradicted that provided by the national leaders.

Towards the end of the study period, each site had to make a decision as to which 'wave' of authorisation (out of 4 waves in total) they wished to enter. Our sites have taken different approaches to this, with the following opinions expressed and factors operating:

- The need to take into account external factors such as staff holidays and the Olympics, pushing sites to seek later authorisation
- The amount of work to be done, pushing sites towards later authorisation
- The fact that if they went later (eg wave 3) they would know more about the process
- The belief that scrutiny would be greater in the early waves, so later authorisation would be better
- The belief that if they went later it would be more difficult, as 'the bar would be higher'
- A belief that if they went later it would be more difficult as the NHSCB would have more to compare them with
- A competitive desire to be seen to be one of the first
- The desire to 'get it over with early' and go in wave 1
- The fact that applying in one of the later waves (in the autumn) would have a negative impact on their ability to run the next contracting round
- A belief that wave 1 would get a higher level of support
- A belief that if they went early they would have more time to work on and overcome any restrictions that were placed upon them
- A belief that if they went later they would be less likely to be authorised with restrictions
- A concern that the lack of readiness of the local CSS would impact on their authorisation, suggesting that it may be better to wait

Key findings: Authorisation

- Approaches to this have varied along a spectrum, from those groups in which the process is led by the GPs, to those in which managers have run the process, reporting back to the wider group
- The guidance published by the NHSCB and the interactive self-assessment tool were generally felt to have been useful
- Support from PCT Clusters and SHA Clusters was valued highly
- The process was acknowledged to be very labour and time intensive, with some expressing concern that this had distracted from the 'real work' of commissioning

3.2 Factors affecting development at each stage

The preceding section has described the development of CCGs chronologically, teasing out the issues that affected them at each stage of the development process. In this section we will draw out across the sites those factors which seemed to be most significant in affecting the way in which they responded to those issues.

3.2.1 The perceived role of key leaders

In every site we were told that individuals matter. Whilst it may be possible to define generic skills and traits that leaders require, the specific personality, experience and approach of leading individuals were argued to be key determinants of how the process played out.

> My observation in terms of the emergent CCG it is really about leadership. If the leadership is good, then everything else will follow. ..Um, in terms of this CCG, it's very well placed in its Chair and Vice Chair because both of them are very strong, capable, strategic leaders, who have, um, a very good view of how this could develop [Manager ID 249].

This respondent expressed clearly the perceived importance of the *particular* people in their locality, over and above structures:

> It's about people and inter personal relationships and trust. And so it doesn't matter whether the PCT goes or not. It makes a hell of a difference if [individual 1] goes or if [individual 2] goes or if I go to some extent now. And all of those relationships have to be re-built and I think there's sometimes a failure to understand that relationships and organisations are not the same. It doesn't matter really whether the PCT is here or not, it does make a hell of a difference if people turnover so regularly that there are no relationships left. And so we've got to try and get some continuity in relationships because nothing works without relationships, nothing can happen that's good. And it doesn't matter how competent new people are or how wonderfully organised the new structures are or how well communicated that change is, if you break all the relationships nothing works until all those relationships have been built. It's just a fact.[Manager ID 244]

In our case studies the Chair and/or Vice Chairs were described as being people who are: able to see an opportunity and grasp it; able to encourage people; prepared to step forward to do the job; possessed of a unique skill set; able to steer people in the right direction; able to be in control; not highly political; and not in it for the glory of the public role. In one of the smaller CCGs, leadership was described as being about persuasion and getting buy-in from people. In other sites a good CCG leader was described as someone in whom they have confidence; someone who is committed, keen, strong, capable, and dynamic; someone who has a very good view of how things could develop, able to develop a very good strategy; and someone who is very clear about what it means to be a GP in commissioning.

This manager went on to explain that it is easier to recognise good leadership than it is to specify in advance what it should be:

> Leadership qualities are very difficult to write down on paper because they're easier to recognise in someone.[Manager ID 244]

In some cases, people told us that it was important for the Chair and Vice Chair to have different attributes which complement each other:

> I mean you can only comment on your own relationship can't you, but ours works very, very well. You know, because [locality lead] is very…he's very visionary, clinically visionary. Very politically astute, and, you know, very good at lots of things at that sort of level. I'm the one who can do the very practical, 'Okay. What are we going to do about this then?' And together…we actually work very well. Because our skill set is complementary.[Lay Member ID 247]

Sometimes, the ability and confidence to challenge was also seen as important:

> And, he's transformational lead and he's grit in the system, really, he's the challenging one, He doesn't care who he, you know, he does care, but, he doesn't really, he's not inhibited, at all, which is terrific! Terrific, terrific, terrific, that's great to see and he upsets people, which, you know, upsets people I respect, as well, but, I don't mind it.[GP ID 102]

A number of sites also told us that it was important to have local leaders who had credibility built up over years of work in leadership positions, and some who had local leaders with involvement in national representative bodies (such as the National Association for Primary Care) valued this. However, there were some potential drawbacks to strong leadership. This GP described the downsides of having leaders who are overly enthusiastic with a strong personality:

> I've also had the feeling that [this CCG] is more [Chair and Vice Chair] than the other members within it. I mean I, I guess they're but they're chair and vice chair but they're both quite strong personalities and I think they're both, they both seem to, erm, dominate what goes on within the group. I think that's ... I mean somebody has to go I guess and but it it it just sort of feels like we don't, I sort of felt like we didn't, the impression was we didn't need to have a meeting 'cause kind of things had already been decided in advance ... which isn't really the way things are supposed to be done.[GP ID 249]

In addition to GP leaders, the personality and behaviours of the managers involved was also important. This manager explained that managers needed to work carefully over time to build up the necessary relationships with the GPs:

> And of course, from my perspective, it was a case of what I didn't want to be doing is going in there and suddenly saying, by the way, we should do this because actually it feels like a good thing. It was more about building those relationships up rather than suddenly saying, I think you should do this and I think you should do this and I think you should do the other. It was about pacing, which is what that was all about.[Manager ID 34]

A number of managers told us that their role was crucial, because they were there all the time, whereas GPs might only be working on the CCG one or two days a week. Keeping an overview of what was going on and providing GPs with support was key. Whilst much work was done via email and online, we were also told by a number of managers that being physically present in a locality where they could meet with GPs and discuss things face to face remained valuable.

GPs agreed, explaining that they needed managers who were there all the time and who could act as a conduit to make sure things are co-ordinated:

I think the interesting thing, from my perspective, is that I work with the network manager and I think her role, within how I function in that particular aspect of the job is quite fundamental, really, because she's at that desk all the time, and things that come through and whiz around, I'm trying to ensure [that things] go through her, not to me, so that she's not a filter, but she's aware of everything that's going on, rather than just coming as an email to me.[GP ID104]

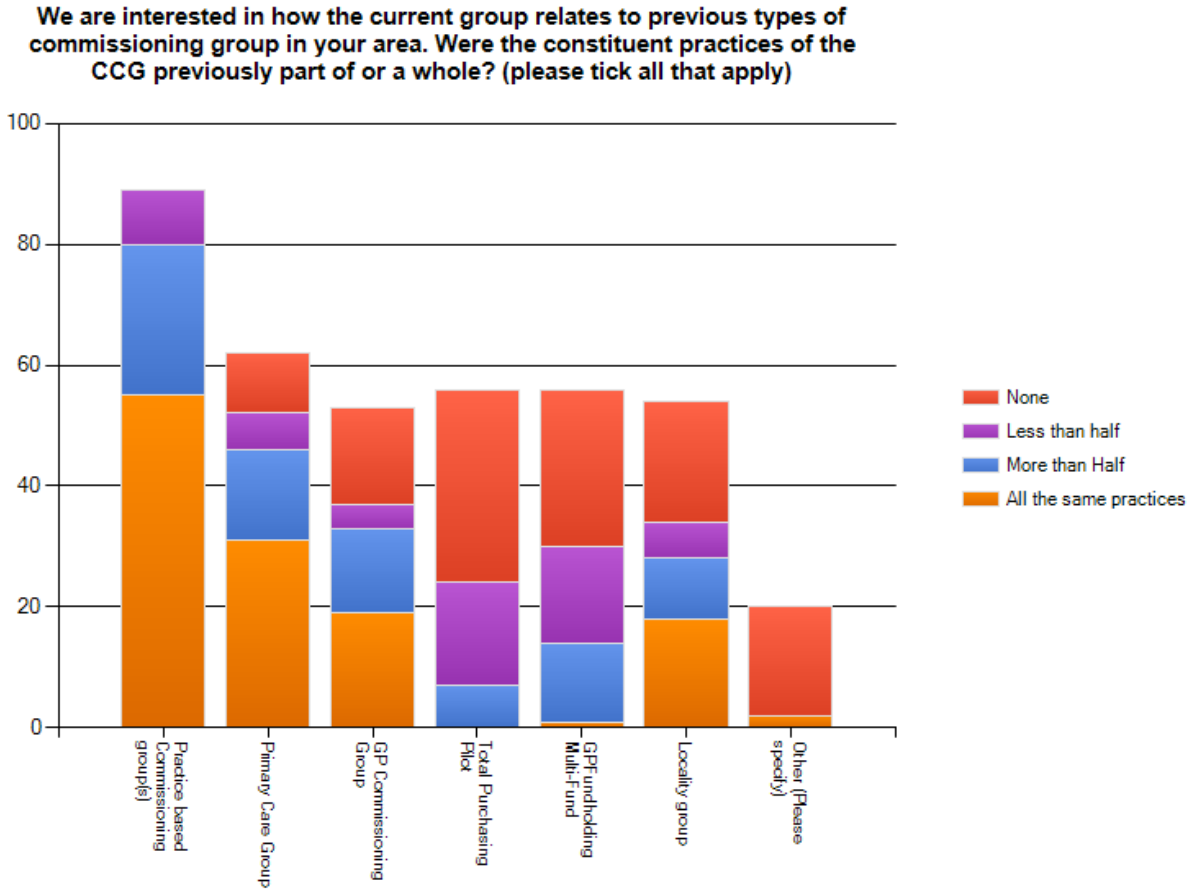
Key findings: The role of leaders

- The calibre and personalities of the leading individuals had a significant impact on the way that the CCG developed in each area
- History was important, in that all of the GPs who initially adopted the main leadership position in each case study site (either as Chair or AO) had been in a local leadership role in the past. Their current skill set was therefore a function of the previous experience that they had built up over the years, and much of their authority came from the track record of trust and relationships that they had built up over time
- This was also true for managers, with GPs keen to appoint senior managers with whom they had developed a good relationship over time
- The development opportunities offered as part of the Pathfinder programme were valued as enabling these existing leaders to develop their skills further, rather than as a means of finding and training up new leaders
- The key task as CCGs move forward will be succession planning to ensure that a new generation of leaders come through in future.

3.2.2 The role of history

The nature of the existing institutional configurations in each of our study sites, including their histories, previously established norms and routines of behaviour impacted on the development of new CCG configurations and their subsequent working. As set out in the interim feedback report, the majority of CCGs in our case study sites initially formed around some previous grouping such as a PBC group or a previous administrative grouping such as a Primary Care Group or Trust (PCG/T). The results of the initial web-based survey (Dec '11) confirmed the representative nature of this finding, with 88 of the 90 CCGs responding to this question reporting substantial overlap with previous administrative or other groupings:

Figure 9: Previous administrative and other groupings (total number of responses=90)



Most commonly CCGs reflected PBC groupings (the most recent grouping before the development of CCGs) but a significant number (46 of 62) stated that the new CCG was similar to a previous Primary Care Group (abolished in 2002) or old GP multifund (14 of 56, grouping abolished in 1998). This shows the enduring nature of local histories, and suggests that some CCGs developed because they reflected a local grouping that is felt to have a natural logic, often with a history of success (Checkland et al 2012).

In general, these longstanding shared histories were regarded as a significant strength by all of our case study sites. In both interviews and meetings, a shared history of 'working together' was cited as a factor that gave the group significant advantages. These included:

- Mutual trust
- Shared values and ways of working
- Shared knowledge of local context
- Shared experience of past successes, such as previously developed schemes to avoid hospital admission

This GP sets out the importance of both trust and local focus:

> We've actually had a forum of GPs in [this site], I'm thinking about eight or nine years now, which has matured and which have learnt to trust each other so we're quite happy to share data about practice performance amongst ourselves. That's not to say there aren't still some tensions within the group

> sometimes. So, as the concept of clinical commissioning groups emerged, so it really wasn't very different from what we were looking to do anyway and we welcomed the ability to start taking control of our patients care as we became more and more dismayed at the ineffectiveness of the large PCT covering the whole of [specified area] which was remote; the staff changed regularly; it wasn't responsive or answerable and you never really knew who to talk to anyway [GP ID 33].

In addition to these articulated advantages, researchers attending meetings, where significant history existed, often commented in their meeting notes upon a sense of ease amongst the GPs in the room, and, in some sites, between the GPs and the managers with whom they had worked over a long period. For example, a manger suggested that for managers involved in the developing CCG, having a deep and long term relationship with local GPs was very beneficial:

> we've, also, had a role that's been with me, from the beginning, which was… kind of, head of PBC, but, that person has got a real in depth knowledge of the GPs and the practices, so, her history is that she's worked with the GP's for many, many years…And, that, I mean, I always say, one of my biggest lessons with working with GP's is, if you stick at it and deliver some change, they will forgive you, when you go wrong, because, they've got a track record that you've done with them… [Manager ID 114]

In another site a GP explained that:

> I think our history. Just, we've got such a… We've got a fairly strong, collegiate type of history here, so that's been helpful [GP ID 4].

.
This collegiality was less obvious to observers in sites where the new CCG was a larger group or one which was based upon previous PCT structures. However, a sense of past history could still be seen in some sites, even though structures were changing:

> So the principle of clinically-led commissioning is already embedded in this organisation, and it partly… it also came out of the, um, wanting to work across the whole county when the PCTs merged together [Manager ID 56].

Where mergers or other changes in configuration occurred, we were told that one of the key issues for those on the ground was the need to maintain the strengths of their historical patterns of working together. We found some early evidence that the strong relational context within which groups with a shared history have developed has some impact on the way in which they see the task ahead of them. Thus, for example, some of our case study CCGs developed out of Practice-based Commissioning Groups, and many of the meetings attended in these sites included a considerable bulk of items that were the continuation of programmes started under PBC. Where other groups such as educational or other local GP forums were involved, the focus of meetings was often upon topics similar to those which would have been discussed in the past, such as educational topics or issues to do with practice development or finance. This is consonant with existing research literature which emphasises the strong and enduring effect of longstanding patterns of interaction on newly formed organisations (Pope, Robert et al. 2006; Coleman, Checkland et al. 2010).

However, shared history could also have negative impacts, if historical antagonisms remained. For example in one of the sites one of the key challenges at the beginning was the tension between localities (which later merged to overcome the perceived divide). The two groupings had been separate PBC groupings and they were said to have different ways of

working and there was a degree of mistrust between the groups that needed to be overcome. Now that the localities have been abolished, a sense of being 'all in it together' is beginning to emerge. The impact of these historical tensions was also illustrated by the following quote from a GP in another site:

> But it's hard, it's a difficult ... [neighbouring area]'s a difficult place. There's lots of politics have gone on in the past a lot of historical falling outs and there's all sorts of things. So it's not simple. [GP ID 282]

Key findings: The influence of history

- Most new CCGs mirror some existing or past institutional arrangement
- These historical relationships are regarded as an important strength, although there is also a risk that historical antagonisms could have an impact
- History can also have an impact on how the current task is perceived and approached
- Where CCGs have changed their configuration, maintaining the strengths associated with their history and shared experiences is a key concern

3.2.3 Interaction with the PCT cluster

The relationship between the developing CCG and the local PCT Cluster was a key factor in the development process. This is a difficult thing for PCTs to manage, as they are effectively managing their own demise and replacement. In an interview, one GP leader described the need for a balance between 'being supportive' and 'letting us get on with things'. At its best, good PCT Cluster-CCG relationships could be a key enabler of progress:

> Q: And, I mean, how do you feel about that as, the PCT's involvement in the CCG development of …
> A: I think it's been quite useful, really, because at the end of the day, you're not - okay, you can't - you try to get into a new system but you can't change the system so much that you're putting patients at risk. So I think it's quite nice to have a Big Brother there to at least look into, say, am I doing the right thing? Obviously, there is that element in which, if there is an oversight from an old system, the new system tends to mould itself like the old system and we need to try and pull away from that, so take the best bits out of the old system and, but still try to keep the new system the way we want it to be formed, really.[GP ID 35]

However, there could also be perceived problems. One of these was a failure of the PCT Cluster to 'let go' of control, which was raised in a number of sites. This example is typical:

> Yes, we are being performance managed to death by several different layers of the NHS now. So for me, I have [Local SHA Cluster] I have [residual SHA], and I have the Cluster, and in the past I just had [Local SHA]. And there's clearly a lot going on around people, understandably justifying their existence..[Manager ID 116]

In one of the sites, the PCT cluster was not fondly looked upon (because it was felt like they were often trying to impose things upon the CCG). Several people described it as the common enemy, which in turn bought the local PCT and the GP practices closer together:

> I think it's a bit of the enemy outside; that you perceive the cluster, which isn't always... it's not... it isn't, but I think amongst the GPs, well, certainly the leadership cadre of GPs, I think it's having an enemy outside to put your... and to say, right, we're going to get it together locally and make it work [Manager ID 2].

A number of groups told us that day to day activity had become more difficult due to the disruption to processes caused by PCT Clustering:

> We find that the IT support, for example, has been horrific, like, you can't even get a printer fixed within less than two weeks, because all our IT support went off to cluster, there's now this big bureaucratic system of writing to cluster support desk, getting them to approve something, someone then actioning it and it being done and it's just so unwieldy. Same for funding requests, which are like funding for high cost drugs and there's the cancer drugs typically, and it used to be dealt with all locally, now it's a cluster team doing it and different members of staff all the time and no rules of linking to us in terms of talking to us on a day to day basis about what's going on or what's happening and it's very, sort of, non-integrated. And it's been very difficult and doesn't really bode well for the sort of services that it can provide at cluster really.[Manager ID 3]

The key factors which appeared to enable productive working between emerging CCGs and their PCT Cluster were:

- A history of local legacy organisations which had worked well together
- Having individuals who had been around for some time
- Developing trust. This was enabled by a history of working well together, but was also an ongoing process as PCT Clusters and emerging CCGs built up a track record of working together to develop the CCG
- Having individuals who could act as a conduit between the CCG and the Cluster:

In addition, most areas ran 'board to board' discussion sessions at which the existing PCT Cluster Board questioned the developing CCG Governing Body on their plans and progress. All of our case study sites reported that these sessions had been helpful.

In summary, the relationship between PCT Clusters and developing CCGs could be both enabling and restrictive. The ambivalence felt by many was nicely summed up by the Local authority observer:

> And I have a sense that the GPs have a guarded view of the PCT Cluster as, you know, we don't want to be told how to do this, we want to have the time and space to shape this ourselves, to take it forward in a way that we think is right, and that isn't prescribed to us. But I think probably also from a GPs point of view, a recognition that actually at the end of the day it's the PCT Cluster that has the link to [SHA Cluster] which in turn has the link to the DH. So at the end of the day if PCT Cluster says it's got to be done this way, then it would be very difficult for our GPs to say, well actually no, we want to do it this way.[Local authority manager ID 6]

Key findings: Interactions with PCT Clusters

- PCT Clusters have been managing a difficult situation between 'letting go' to enable CCG development whilst still maintaining control of the system
- At best, this relationship has been extremely supportive and helpful
- In other areas there have been frustrations, with CCGs complaining that their local PCT Cluster was trying to be too controlling
- Trust (usually built up over time) and good interpersonal relationships have been the key enablers of supportive interactions

3.2.4 Interaction with SHA Clusters

The local SHA Cluster has been the key organisation in managing the development of CCGs through to authorisation. In general, our case study sites told us that their local SHA Cluster had been helpful and supportive. In some sites this was a very close relationship, with an SHA Cluster representative attending CCG meetings in order to help them prepare for authorisation. Where this occurred, respondents found it very helpful, in particular because it provided clarity about what would be required. In other areas it was a more 'arms' length' relationship.:

In some areas the SHA Cluster published detailed guidance for CCGs on particular topics. In most cases this was found to be helpful, but on occasion this guidance either contradicted or was more directive than that emanating from the Department of Health as a whole, which could be confusing and unhelpful, as it left CCGs unclear as to what they should do:

> [Local SHA Cluster] are saying look, take a sensible approach, work with your local people…um, and try to get that into a fit shape. Er, that it offers stability, it means you can have more control over the economy of scale. …On the other hand, you've got, um, some people in the Department of Health, or some utterings from the Department of Health and, um, the Ministry, the Secretary of State in particular, saying no, no, no, CCGs, you can buy it from wherever you want.[Manager ID 348]

Overall, the aspect of SHA Cluster support that our case study sites found most helpful was the provision of regional workshops and meetings, often including headline speakers from the Department of Health or developing NHS Commissioning Board. These were considered particularly helpful, especially in the early stages, as CCGs felt that, in a confusing situation with little concrete guidance it was immensely useful to be able to hear direct from those charged with implementing policy.

Key findings: Interactions with SHA Clusters

- Relationships with SHA Clusters have varied between very close, including the attendance of SHA Cluster managers at meetings, to more arms' length, involving more formal reporting and responding to concerns
- Some SHA Clusters issued detailed guidance which was not always consistent with the messages from the DH as a whole
- Regional workshops and meetings were particularly helpful

3.2.5 Local factors

In each of our case study sites there were unique local factors which had an impact on the way that the CCGs worked and developed.

<u>Crossing boundaries of different types</u>

Whilst the official aspiration was that CCGs would generally establish geographical footprints which mirrored Local Authority boundaries, in practice a significant minority have established configurations which cross those boundaries. A detailed discussion of the impacts of this will be provided in section 3.5.1, but it is worth simply noting here that crossing boundaries in this way does generate complications, from the purely practical need to, for example, attend twice as many meetings, to the less easily defined but no less real need to accommodate different ways of working. In addition to crossing LA boundaries, some CCGs also cross other boundaries such as those between two legacy PCTs. This again can generate extra work:

> You've got two PCTs and two sets of accounting principles, etcetera, etcetera, and every time you pull a thread it pulls a whole raft of other things that come with it. So it's been very difficult and very confusing and very time consuming and we don't...still don't have all the information, to be honest, to do it. [Manager ID 224]

In spite of these difficulties, interviewees at both sites affected suggested that cross boundary working also had benefits. The flip side of the frustrations over different ways of working was that best practice could be shared and promoted across the CCG. Towards the end of this research period informants were noting how they had been working well together and co-operating and how the problems associated with cross boundary working were being resolved. In site 5, differences around joint presentation of financial data were rapidly being harmonised and in site 1 controversy and hard feelings over the status of a cross boundary practice were satisfactorily resolved. In both sites there was a cautious optimism about the possibilities and opportunities of integrated cross boundary work.

> I think they work together so, so well. I think they all have different strengths and some challenges, but I think the success as a CCG was the coming together of A and B with those GPs that are actually committed to making this work. … So, I think, as a CCG, our strength has been in the face of adversity when we've had all the trouble from LA1, that the GPs have kept going and working really hard to make this work for us. [Manager ID 288]

It could also enable creativity:

> You get the benefit of double lots of ideas, you've got two lots of energy, it's fantastic. … So it's neither, it's not a question of right and wrong, it's just different. And we're trying to create a single entity from two very different predecessor arrangements, it obviously creates some tensions. So there are some challenges. Having said that, there's also a lot of benefits… We probably picked up three or four months' worth of progress in about three or four weeks because of the stimulus of having to respond to this agenda.[Manager ID 244]

<u>Struggling providers</u>

As CCGs have begun to understand and explore their new commissioning roles, the importance of their relationships and transactions with hospital Trusts have featured prominently in meetings and interviews. Negotiating shifts in roles as GP commissioners attempt to commission new pathways, decommission others and reduce hospital admissions has led to frustrations and tensions in some instances.

> [Hospitals] don't seem to be able to get the message that there's still that thing between trust and commissioners; we want to work with them, but they

> still don't trust us. We want to trust them, but they can't trust us, and we've still got to get over that barrier. [Manager ID 116]

These relationships will naturally form an important part of the unfolding story of the development of CCGs. In those sites where hospital Trusts are currently in a state of crisis this has led to added challenges for CCGs and has obliged them to adapt and change perhaps more rapidly than their counterparts elsewhere. In one site, the fact that one of the hospital Trusts is in financial difficulties has led to both the CCG and the Trust looking at solutions to maintaining a hospital service and serving the local population.

> We do have a bit of vision for integrating health and social care because the [local] Foundation Trust is a small FT and it is struggling financially. It has to look at doing things in a different way and the way they think that they can survive is by putting more care out into the community so breaking down the secondary care/ primary care divide and part of that will be integrating health and social care as well, so alternatives to hospital admission basically. …And [local]Foundation Trust are up for that because that's the only way they're going to survive because they need to reduce their hospital base and spread out into the community more. [GP ID 28]

This FT is small and is one of three acute Trusts that the CCG refers patients to. In this instance, although there is financial difficulty, the Trust and the CCG have been able to respond to the crisis in a creative and positive way. In another site, however, the CCG finds itself dealing with two hospital Trusts, one of which is in severe financial crisis while the other faces significant quality and safety issues. For the CCG this has resulted in enormous amounts of time and energy being needed to manage these crises. In terms of CCG development this has meant that a lot of attention has been directed at handling crises and examining contracts with the Trusts. On one hand, this has been stressful and required considerable resources in terms of personnel and time; on the other hand the CCG has now built up expertise and confidence in the contracting process. Nevertheless, the local crises have obliged the CCG members to ask themselves searching questions about their future roles and responsibilities in relation to struggling Trusts.

> In terms of contracts they need to get back into performance management mode with peer to peer performance meetings and reviews ensuring quality of patient safety. They need to move away from a tick box culture. [GP ID 162] asked whose responsibility this will be in the future: Monitor, the CQC or the CCG? [Manager ID 169] said that the CCG will have a big role in the future. [GP 165] asked what would be different in the future. [Manager ID 169] replied that we will lead these conversations in the future – we will have a leadership role. [Extract from fieldnotes, Executive meeting March 2012 M30]

In spite of the optimism and confidence about their forthcoming leadership roles, concerns centred on: patient safety and delivery of services; how the crises would impact on the authorisation process; and whether CCG commissioners would be blamed for future Trust failures.

In one site the crisis concerning serious breaches of quality in one Trust had led to questions being asked about the culpability of GPs in not raising the alarm sooner

> We need to look at ourselves and accept we are 'young commissioners' and need to learn from this. The Trust also needs to respond to our queries in future. [Extract from fieldnotes, Locality meeting February 2012 M31]

The weight of responsibility in dealing with struggling Trusts has obliged this site to look at the roles of their senior leaders, concluding that they will need a highly qualified manager in a Chief Operating officer to take some of the load off the Accountable Officer:

> And [senior manager's] really concerned that his experience of doing the role over the last few months as it's developed is that, you know, actually because of the way we're organised, he finds himself doing an awful lot internally about sorting out who's doing what and how and, you know, sort of almost like he's doing a chief operating and accountable officer role, and feels the need to split them really. [Manager ID 173]

Thus, in the site affected, struggling Trusts have both hampered CCG development and propelled them into a more proactive role in negotiating with these Trusts and sensitising them to issues around finance and quality.

Disruption resulting from mergers and reconfigurations

Although those who had made decisions to merge were generally pleased with the outcome, there was an acknowledgement that the disruption associated with this had delayed development overall:

> ..I think probably my colleagues in our CCG, feel that actually, having come together, it's set us back by two or three months, really…[GP ID61]

Mergers brought about a dampening of enthusiasm for some participants who felt that initial promises of being able to work in locally decided configurations had been illusory. Members themselves came to the conclusion that size did, indeed, matter and that economies of scale needed to be achieved in terms of management support and in terms of bargaining power.

> I think that each of the localities was quite disappointed I think in the early days when the legislation came out it was all about local autonomy and local leadership; and I think each of the localities thought that there was a real opportunity for them to lead their local communities and to work autonomously. But as the scale of the change and the responsibility that goes along with it became apparent I think they've accepted that actually that's not a realistic way forward. [Lay member ID 273]

Having made the pragmatic decision to merge, both sites are still exploring the ways in which the former CCGs, now reconstituted as locality groups, relate to the larger umbrella CCGs of which they are now a part. By May 2012 there was a sense that that the work of the CCGs was being swept forward by the activity associated with the authorisation process. By contrast, the work of the local groups was continuing as before but at one step removed from the action taking place at the CCG level. The exact nature of the roles of locality groups in relation to their CCGs was still not clear and participants felt that this relationship was in the process of evolving. This will be discussed further in section 3.4

Key findings: Local factors

- As might be expected, locally specific factors had a significant impact on how CCGs developed and approached their task
- Some of these factors are time limited – for example, the fall out from mergers is likely to settle over time. However, others, such as struggling local Trusts and crossing LA boundaries are issues that will continue to impact upon these CCGs over time

3.2.6 Politics and national policy

The development of the current reorganisation has been a highly political process. Inevitably the associated media discussion and polarised debate has had an impact on those working on the ground. Overall, we observed the following occurring in part as a result of the difficult political situation:

- *Delays and confusion* caused by the legislative 'pause'

  'Q: What do you see as being the kind of biggest need or gap for you guys, as a group of clinicians and the job [you must do]?
  A: Transparency from higher up. The listening exercise didn't help, the debate about the Bill didn't help. I think, I can understand why it was done but it just didn't help us because we were already in that mould. It just put, the colleagues pulling in the opposite side saying, why are you getting on with it? There was confusion as to what we were going to do, there was confusion about how much we're going to do and how we're going to do it. So I think that's not been very helpful..[GP ID 35]'

- *Uncertainty* (and some frustration) as ongoing consultations generated additional requirements such as having a Consultant on the Governing Body of the CCG

- A *sense of being caught up in a political process*, in which their actions were interpreted by all sides as being either supportive or unsupportive. In general, most of those working locally to implement CCGs appeared to see themselves working within whatever system they were given to try to maintain and improve services to patients.

  'What we are trying to do, which is what we've always done here, is we are trying to make sure that we organise ourselves locally to mitigate the risks of any national reform and to make sure that we're doing the best we can for our patients.[Manager ID 54]'

- The fact that *many different things are changing at the same time*. CCG development continued during the legislative 'pause', but other aspects of the new system (such as the development of Local Healthwatch and some Health and Well Being Boards) were to some extent put on hold during this time. This generated a multi-speed pace of change, making the development of new relationships difficult.

Together, these things caused some difficulties across all of our case study sites. This manager with HR responsibilities was particularly concerned that those working locally may be blamed for changes in guidance which had come from national policy:

> We're looking at the HR messages we've got to give out next week, and we're doing a series of HR road shows again. We look at what we said in January, which was the nationally mandated line in January, there isn't one

> bit that's consistent between January [messages] and next week. And it's no fault of anybody locally.[Manager ID 173]

Finally, respondents in all sites told us that, whilst they welcomed the focus on GP involvement in commissioning, the disruption associated with the changes had not really been necessary:

> I think they should have just put GPs on the board of PCTs; save themselves a whole load of hassle. I mean I don't have a problem at all with clinical leadership; I don't have a problem with allowing clinicians to have more input and more – rather than just influence – to actually provide leadership, but I think that to actually set up entirely new organisations I think has been crazy, and I think it will be extremely expensive. But that's not to say I don't support the policy, I just think there would have been a much simpler solution; the policy could have been that PCTs they could have changed the nature of the statutory order that legislates for PCTs and says that in future there will be a majority of clinicians or whatever sitting in executive positions on the board. [laughter] Because it would have had exactly the same effect.[Manager ID 255]

However, whilst expressing a similar sentiment, this manager wondered if the disruptive break might have been necessary:

> So, I would hope that it feels different, certainly, having, you know, because, part of the view is, could you not just have turned the PCT upside down and have a GP, either, chairing it, you know, have a chief exec and, then, have a mixture of lay non execs and GP non execs, on your board? And, maybe, you could have done, it's just how quickly that would have felt different, I think, there had to be a, kind of, break, before it could be re-cemented.[Manager ID 114]

Key findings: National politics and policy

- The development of CCGs has been affected by significant national political issues
- Delays and uncertainties caused by the legislative 'pause' caused some difficulties
- In general, our case study CCGs do not wish to be seen either as 'supporters' or 'opponents' of the national policy; they see themselves as working to improve care for patients regardless of the national policy situation in which they are operating
- The fact that change was affecting many aspects of the NHS at the same time caused some difficulties
- There is widespread support for the idea of greater clinical involvement in commissioning. However, respondents in all of our case study sites told us that they believed that this could have been achieved without the need for the current national reorganisation

3.3 The Pathfinder experience

This research was specifically charged with providing evidence about the processes by which the development of CCGs was supported and enabled and their experience of the relatively 'permissive' approach adopted. This section of the report will use evidence from the case studies, the web surveys and the telephone interviews to provide an overview and assessment of these processes, in particular which aspects CCGs found most helpful, and what support they feel they need in the future.

3.3.1 Enrolling GPs via the Pathfinder programme

Firstly, the 'Pathfinder' approach proved to be an extremely effective way of enrolling candidate CCGs. Within a few months of the programme being announced virtually the whole of England was covered by Pathfinder groups. Our case study work and the replies we received to both of our web surveys suggest that the key elements at work here were:

- Experience of previous NHS developments in which being in the vanguard was perceived as having yielded benefits such as additional resources or support (for example GP Fundholding)
- A degree of competitiveness, in which groups signed up in order to obtain wider recognition for their achievements and to consolidate their position as local leaders
- The development of a sense of momentum, in which even those who were originally not keen felt that they would be left behind if they did not join

Official rhetoric, which emphasised voluntarism and the opportunity to test arrangements, was helpful in enabling the enrolment process, as these encouraged groups to feel ownership of the process. However, this also caused problems, as those who later felt pushed to change their configuration described feeling let down or betrayed.

Respondents in those sites who were first wave pathfinders enjoyed the early kudos and publicity including, for example, trips to Downing Street and meetings with senior DH staff. They also described feeling that in the early stages their feedback was valued and listened to, but that once more waves had been authorised this ceased. This is probably inevitable, given the numbers involved, but it was experienced negatively by those who had initially felt themselves to be 'special' in some way.

> So, to begin with, it was really important and feeling that we'd done something, that we'd gone down to London, that we'd met David Cameron, you know, that we'd had the letter back from Andrew Lansley, it was great, it felt really positive and, clearly, they can't, you know, deal with that when it's everybody going forward, can they? So, I think, it felt very positive, I think, Barbara Hakin is quite important, in that, she does…I think, when she sends out monthly or bi monthly path finder bulletins and, I think, they're quite helpful, I think, they're quite a good reading of what's going on and you pick up stuff, there, that, perhaps, you wouldn't get elsewhere. But, other than that, everything else seems to have been mainstreamed, you know, most of the stuff, we, now, get, either directly from NCB or we'll get from the cluster SHA or the PCT cluster, it's main stream communication, it's not like you're the special group who are trying things out over here…… So, is that how you went into it. You thought, you know, almost, like, a pilot, kind of thing, this is what we're doing, we're going to try things out, experiment on it, if it works other people can use it and if it doesn't…And, so, feed back into a process. But, they don't even ask for feed back any more, that's gone! [Manager ID 114]

There was, however, a more sceptical view expressed by some, with this GP arguing that the point of the Pathfinder programme was to provide political cover:

> I actually think it was more an ability for the Department of Health to be able to say look how successful our reforms are, look how many practices have joined together to go into Pathfinders, look what proportion of the population are in a…covered by a Pathfinder organisation. ….I don't think I got anything out of specifically being a Pathfinder, that was any different to had we not gone down that route. And the gist of it was, we filled in a simple application form and they said you're a Pathfinder.[GP ID 284]

Others took a more positive view, with this GP describing how the attainment of Pathfinder status had felt like an affirmation that they were on the right track. It was seen as positive endorsement of what they were doing:

> I think we saw it as part of the movement towards becoming approved, accredited, or whatever you want to call it for CCG. If you could get accepted as a pathfinder it meant that you were going somewhat in the right direction…..But, realistically, I think it was a philosophical benefit, it felt as if we were taking a step forward. In practical terms, I don't think it's made any difference at all.[GP ID 33]

Overall, the findings from our case studies suggested that, once the 'badge' of being a Pathfinder had been obtained, Pathfinder status had little further significance. Indeed, many told us that they did not regard themselves as a Pathfinder or as part of a programme, but that they saw themselves as a 'developing CCG' with access to a variety of possible sources of support, some of which were provided by the national Pathfinder support team, but others came from elsewhere. This was confirmed by both our April/May web survey and the telephone interviews carried out in May, in which respondents were asked to tell us about their experiences of being a Pathfinder CCG.

3.3.2 Impact of national guidance and central policy

Part of the rationale behind the Pathfinder approach to CCG development was that there should be no national blueprint, with developing CCGs trying out different ways of doing things and feeding their experiences back to the central team. However, CCGs were generally somewhat sceptical about this. There was a general feeling amongst our case study sites that, although they were told that they could find their own way of doing things, this would not last and eventually they would be told what they should be doing:

> They said, basically, they've given us a packet of grass seed and a roughly flat field; sow your seed, mark the white lines out where you like, put the goals where you like, it's your game, you design the rules. Not used to that. And furthermore, we know damn well that actually, that won't happen. We might put the seed down but then the Government come back [and say] put potatoes in there instead, or whatever.[GP ID 33]

This belief that the apparent freedom to develop as they wished was illusory was reinforced by a number of events over the period of the data collection. These included: firm steers from SHA Clusters as to what was or was not acceptable in terms of size or configuration; communications from the Chief Executive designate of the NHS Commissioning Board which implied that the board would take a strong approach to managing CCGs; direction from the DH that mandated PCT Clusters to commission an NHS 111 service whether this was a local priority or not; and instructions from the DH that at least three services should be put out to Any Qualified Provider procurement. Across our case study sites there was a general

recognition that the 'tightening up' of rules and guidance that they had experienced was probably inevitable, given the need to keep the system running and to be accountable. This manager explained that he felt that the dichotomy was between an overall vision that saw GPs designing the system as they saw fit, versus a pragmatic need to ensure that the system continued to work in the meantime:

> And of course they can. I mean the way this, there's the, what we've got here I think running, and it's pretty transparent to me actually, is we've got [an overall vision expressed] in the most general of principles. And [those who are] accountable for the NHS putting in place all sorts of rules and regulations that stop it being a complete shambles. And the two are absolutely in dynamic opposition at times. So [they say], be any size you want, appoint anybody you want, configure any way you want, call anything yourself …any way you want. And [senior NHS executives] say: but you've got to be viable, you've got to have an identified job, you've got to be accountable, you've got to have competence, you've got to have money. And so two sets of rules don't accord at all. And of course because this actually has to work in the real world and not just over the dinner table with your mates, it's [the more directive] view that's pre-empting. So we're not playing a game. This isn't an academic exercise, this is real money, real people's lives, a real job to be done. And so of course the GPs are being constantly disappointed by the kind of grim realities of life. It would be lovely to organise any way you like, but actually you've got to be able to account to the public because it's their taxpayer's cash.[Manager ID 244]

Some told us that the initial lack of firm guidance gave them an opportunity:

> The more I hear/speak to 'people upstairs' the less clear it is there is a definite plan. So this gives an opportunity to stake a claim and be creative. So long as do so within the context of what other people are doing.[GP ID 1]

However, others found it unhelpful. This respondent explained that, in the absence of clear national guidance they had developed things locally in their own way. However, they were then challenged because this didn't meet with an unstated national idea as to what should be happening:

> I guess the frustration has been that in the absence of National policy there has been some [areas] where we've wanted to do things locally that deviate from the, what people think is going to be the National policy, you know, we've had some challenge around that, but …but when we said, well, what are we supposed to be doing, then there's a vacuum.[Manager ID 54]

We saw something similar in a number of sites where, in the absence of clear national guidance, participants in meetings would try to guess or imagine what the Department of Health (or the NHS Commissioning Board) 'really' wanted to happen. Sometimes this went further, with people stating categorically that a certain course of action either was or was not 'allowed', even though no firm guidance had at that time been issued. The impression given overall was that those who have worked in the NHS for a number of years are so used to acting according to firm top down guidance that the absence of such guidance was experienced as destabilising.

Some told us that this early lack of guidance meant that they were unsure whether to get on with things in their own way or to wait for guidance, with a general concern that

if they did push on in their own direction they would later have to make changes. We did in fact witness this in a number of sites, causing some problems and irritation.

> I think the lack of guidance is a serious problem. ….So, the trouble is, if you want to get on and do things, it's been seriously disconcerting, because you're very anxious about going ahead if, in fact, there's a risk, that by doing so, somebody's going to say, oh fine, but I'm afraid we've decided that's completely not fit for purpose, so you're now, you know, you're in special measures because you're so far behind the game.[Manager ID 3]

Others described feeling 'knocked off track' by changes in guidance and policy:

> I think it's a stop start, and every time you think we know where we're going, um… And we've tried to be as positive as possible and say we won't let things knock us, knock us off… and the vexed issue of structure for the CCG is, is a great example, we've never, been able to nail down the structure and give certainty to people and, um, the confidence that they can then get on and deliver, because there've been so big…so many big policy changes around it that it's always kept knocking, knocking things off, off track [Manager ID 171]

This GP explained in a meeting that it was the number of 'layers' in the NHS that was the problem:

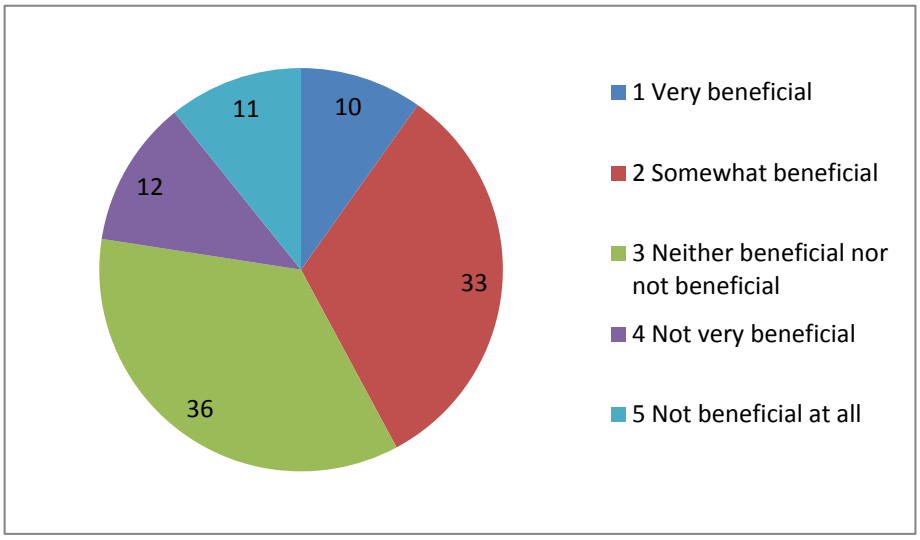
> [Chair] said that the general 'noise' was that they could do what they want to do. The problem is that when these findings get filtered down from above through several levels they tend to receive a message of "you must".[Extract from Executive meeting March 2012 M6]

Over time, more detailed guidance was issued. In particular, the clear guidance issued to help CCGs prepare for the authorisation process was welcomed.

3.3.3 Experiences of Pathfinder Groups

In the second web survey, respondents were asked about their experience of being a Pathfinder. Figure 10 shows these results:

Figure 10: Overall experience of being a Pathfinder group (N=102)



Respondents were then asked to tell us what aspects of the support that they had received during their development had been helpful, and what had been unhelpful, listing up to three things in each category. In total, 127 'helpful' factors were listed (from a total questionnaire response of 114), and 90 'unhelpful'. These have been categorised as shown in Figures 9 & 10. As can be seen from the figure, in general the most helpful aspects of the programme were seen to be the networking opportunities that it provided, access to information and the credibility associated with acquiring the Pathfinder 'badge', both with external agencies and internally amongst constituent GPs. Only 2 respondents mentioned in answer to this question that they had felt able to influence national policy. In terms of unhelpful aspects of the programme, the largest category was those who told us that they did not feel that the programme had had any major impact upon them. Others in this section generally related to the volume of work, including a number who complained about the volume of emails that they received. In addition to those categories shown in figure 10, 3 respondents mentioned a lack of clarity in guidance, 3 said that their PCT Cluster or SHA Cluster had been unsupportive and 3 mentioned a lack of access to development funding. These issues were followed up in the telephone interviews. In the 38 interviews, 6 respondents described the networking opportunities provided by the programme as being helpful, 5 said that they had appreciated the opportunities for personal and organisational development and 3 said it helped stimulate GP thinking / engagement. Ten said that, although it had been a challenging process, they had found it personally exciting and rewarding, and 17 said that the Pathfinder programme itself had had little impact on their development. When asked about the unhelpful or problematic aspects of the process, 13 respondents mentioned the lack of guidance, especially early on in the process, and suggested that there had been a lack of clarity as to how they should proceed. Eight respondents said that they had found the volume of work required to be significant and difficult to maintain, and 5 mentioned the disruption caused by the loss of experienced PCT staff. Four respondents would have liked to see more organisational development support.

Web survey respondents were asked what additional support they would have liked to have received. In total there were 47 replies to this question, shown in Figure 11. The largest group of these suggested that greater clarity in guidance would have been helpful, with a number suggesting that better managerial or administrative support would have been helpful.

Five suggested that a named contact at the NHS Commissioning Board would have been useful.

The final question in this section asked what support the respondents felt they would like from the NHS Commissioning Board in future. There were 78 replies to this question, covering a wide range of topics. The most common suggestions are shown in figure 12. These suggest that CCGs are concerned that the NHS Commissioning Board should not be too directive in their relationship with CCGs, allowing local development. In addition, respondents suggested that they were anxious not to be overloaded with administrative or reporting requirements, There would also seem to be an appetite for ongoing networking opportunities amongst CCGs, with sharing of best practice. Other suggestions offered by one or two respondents in this category included:

- Clarity around primary care contracting and performance monitoring
- Partnership working to commission primary care
- Ongoing GP mentoring / training in management and collaborative intersectoral working
- Reasonable timescales and adequate notice periods
- Named contact to develop relationship with
- GP contracts to reflect CCG performance
- Giving CCGs authority to develop primary care
- Fair management of specialist commissioning and QIPP
- Political support
- Mutual respect
- Consideration of clinical workload for GP leaders
- Appreciation of added value of GPs to commissioning
- Dispute resolution assistance between PCT and CCG
- Less transactional approach

In the telephone interviews respondents were asked to enlarge upon these issues. In the 38 interviews, 12 respondents said that they wished the NHS Commissioning Board to take a relatively ‘hands off’ approach, allowing CCGs to develop without imposing significant burdens such as targets and demands for information. In addition, nine wanted the NHSCB to be realistic and tolerant of what CCGs could achieve as they set out. Four wanted clearer guidance around specialist commissioning. . Finally, 7 respondents told us that they were concerned about the lack of clarity over the future management of the GMS contract, suggesting that they were concerned that CCGs will have responsibility for quality in general practice, but will have no contractual levers by which to exert their influence.

Figure 11: helpful aspects of the Pathfinder programme

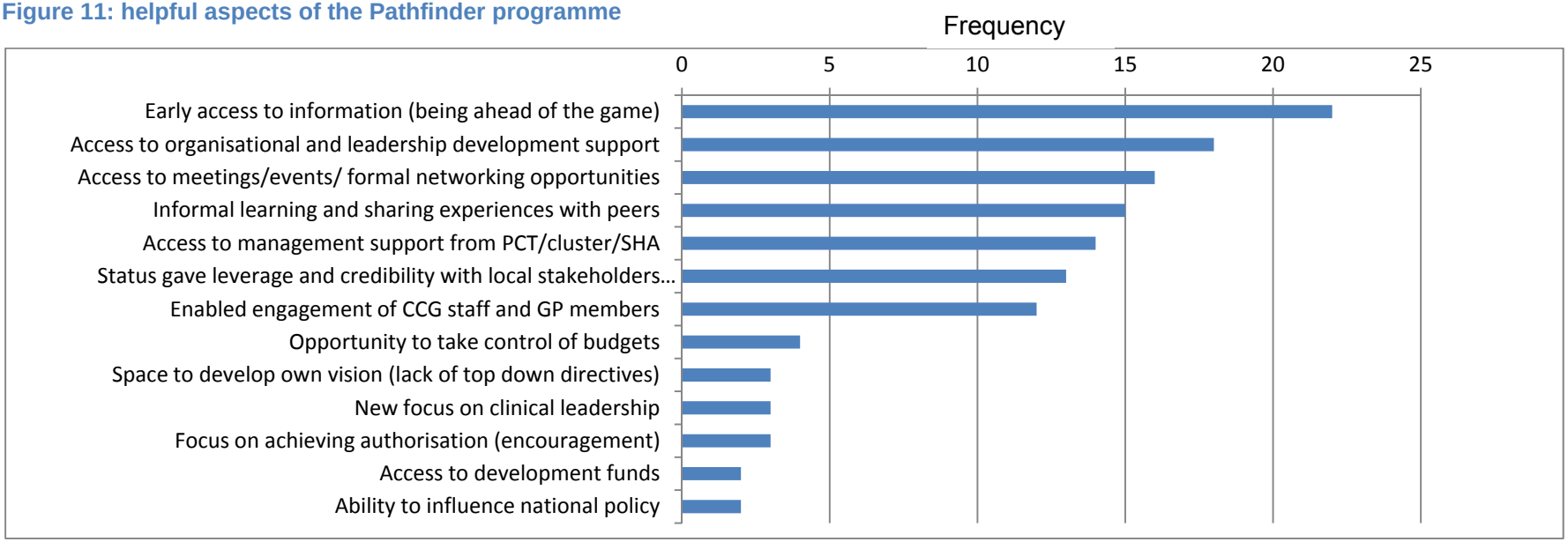


Figure 12: Unhelpful aspects of the Pathfinder programme

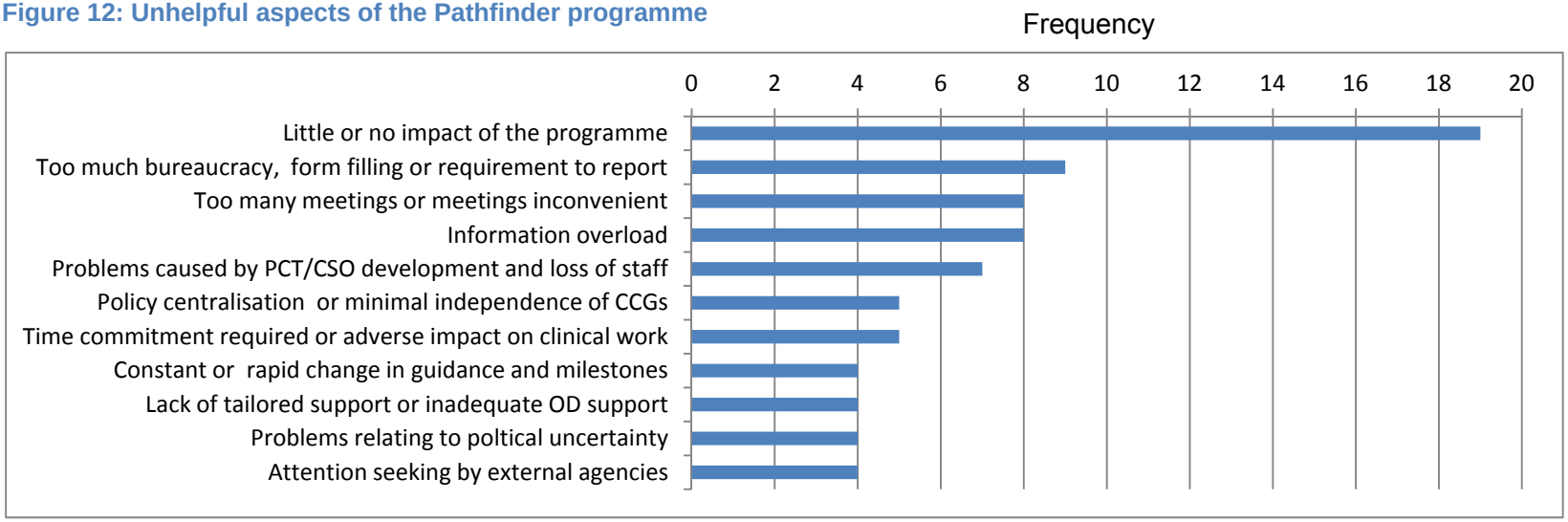


Figure 13: Additional support that would have been helpful

Frequency

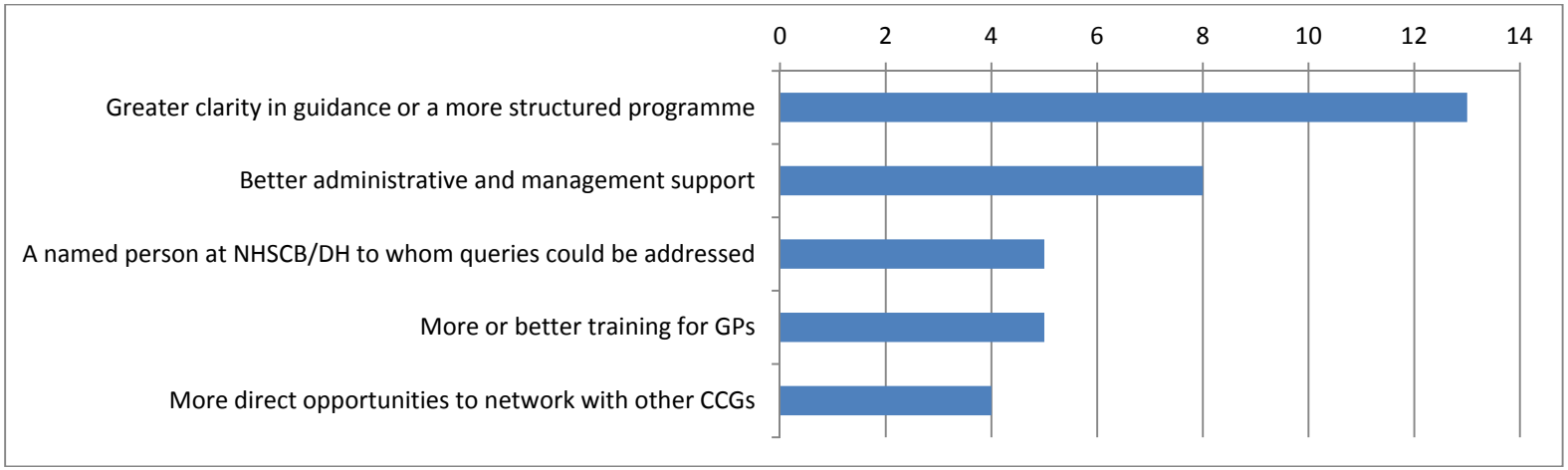
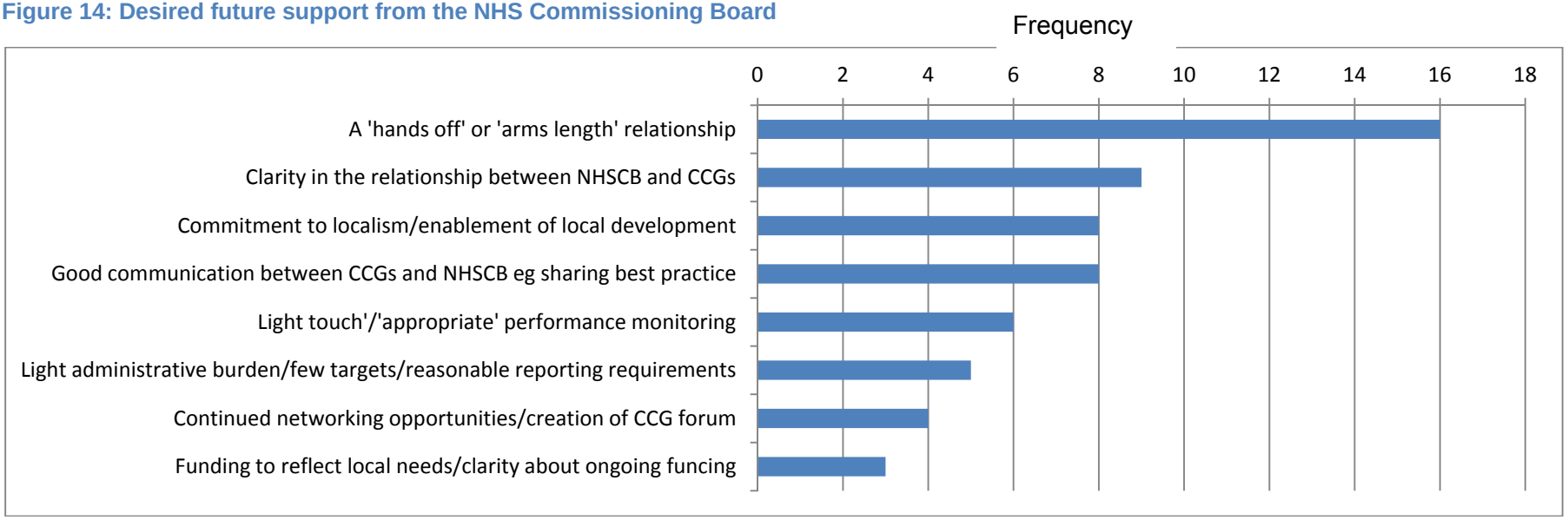


Figure 14: Desired future support from the NHS Commissioning Board



Key findings: Pathfinder experiences

- The Pathfinder process was a very effective way of generating momentum and achieving sign up for the development of CCGs
- Participants generally regarded becoming a Pathfinder as a 'badge' that they needed to achieve in order to gain credibility and to begin their development
- In terms of practical support, the national and regional meetings organised by the Pathfinder programme were regarded as helpful, especially those at which national leaders appeared. Some groups found the interactive self-assessment tool to be particularly helpful. Other aspects of the Pathfinder programme (eg online forum) were not prominent in our case study sites, and were not mentioned by survey respondents
- Opportunities to network with peers were valued
- In general, the early promise that Pathfinder CCGs would be able to influence the overall direction of the policy was not felt to have been fulfilled. In particular, those who had signed up as Wave 1 Pathfinders felt that the extension of the programme to all groups had removed any influence that they might have had in the early stages
- There is a general feeling that the development of CSS has been disruptive to the process, largely due to the destabilising effects on the PCT Cluster staff supporting CCG development
- The lack of clear guidance (especially in the early stages) has been a particularly problematic issue for many groups
- There was a perceived disconnect between early encouragement to develop their own ways of doing things and an emerging sense that there was an official agenda which must be adhered to
- Individuals in leadership positions have found the process to be challenging but personally rewarding
- There is a clear appetite amongst CCGs for the NHS Commissioning Board to avoid being too directive to CCGs, allowing them to develop and to respond to local needs with a minimum of central directives
- There is an emerging concern about the future management of the primary care GMS contract, with respondents asking for greater clarity as to how the separation of responsibilities will operate in practice

3.4 Practice-CCG relationships: being a membership organisation

Official documents have emphasised that one of the key features of CCGs which distinguishes them from previous commissioning organisations is the fact that they are 'membership organisations', with individual practices signing up to be 'members': 'CCGs are also membership organisations, accountable to constituent GP practices' (NHS Commissioning Board 2012c : p3). Governance guidance issued in Feb 2012 (NHS Commissioning Board, 2012e) suggests that member practices should be actively engaged with all key decisions in setting up the CCG, and that they should collectively develop their constitutions. In this section of the report we will discuss what being a membership organisation meant in our case study sites, and how far it conformed to this ideal.

3.4.1 Ownership of the emerging CCG

Within our case study sites the key issue that arose relating to being a membership organisation was the question as to who actually felt ownership of the CCG. The term 'membership organisation' implies that the members own the organisation in some way, and, whilst a number of our sites aspired to make this a reality, all of them were struggling with what this would actually mean in practice. Two of the smaller case study sites were trying hard to encourage their grassroots members to feel ownership of the organisation as described in the governance guidance (NHS Commissioning Board 2012e). This GP described a meeting where he had tried to get his colleagues to understand the new world they were in:

> We were in a kind of dreamland for a while, because everybody told us PCTs were disappearing, and the Clinical Commissioning Groups had moved on, but we were still going to the PCT building and we were still seeing the same faces around the table. And, okay, the chief executive left, and the finance director left, but that, they are up in the strategic highlands, and that made no difference to the guys and girls down in the valley, so there was a period of surrealism, and what I've tried to do…So, I can remember the attendance at our meetings was kind of intermittent. It wasn't great, so about a year ago I threw everybody who wasn't PCT out, and everybody looked around the table, and I said, yes, and that's it. This is the brave new world. You are the guys and girls, and these guys are all going. You, you know, you may be seeing them round the table today, but in a month's time, or two months or six months' time they're gone. What do you want to do? You know, have the reality check; smell the coffee here. And they, and people, I think, suddenly I'd made it real for them. It was tangible.[GP ID 4]

In Site 1, the need to get the GP membership to take ownership of the process was revisited in almost every meeting. Their Council of Members met monthly, and their aspiration was to have the agenda set by that group. This Lay member expressed it thus:

> For me the big thing is about how you get the members really engaged in that, and I know [GP ID 284] and I had different views about this, because [GP ID 284]'s view was they're there to hold us to account and I said if you would just on that premise it's not going to work and so on, you're then to appeal to them to help you build this and actually at the end of the day they can then turn round and say "Well did you do what we asked?" but that's a small part of it and if you get into the them and us, you're holding us to account you're finished before you start. You need to get in there "Help us, help us, you've got the knowledge."
> [Lay member ID 281]

In order to bring this about a number of development workshops were held for the Council of Members, at which they worked through in detail the roles and responsibilities of each group. In addition, at each meeting of the Council of Members the Chair re-iterated the need for the group to take ownership of the process, and asked them to think about how they might set the agenda.

Furthermore, they talked explicitly about the Council 'holding the governing body to account', and invited them to do this each time they met. Later on in the data collection period they began to feel that progress was being made:

> We also have a check and balance of the Council of Members, and my feeling initially, was that meeting was far too large…..there were thirty-four people sitting around. But in actual fact, if we watched how the conversation flowed at the last meeting, I actually felt it was really quite useful. The purpose was one, to hold us to account, but also to feed us information about what's a problem. And you saw with the Mental Health Strategy. "This is wrong". People giving both specific examples and endorsing broad feelings about how it did, and take all that in. And then go back to the provider of that service, and say "This is what everybody is saying about it. What do you think you're going to do to change it?" So to be at that stage, is actually really quite exciting because it's almost showing how we're going to operate in the future. [GP ID 283]

However, the downside of allowing the Council of Members (CoM) such a significant role in the development of strategy is that the resulting decision making processes could be very complicated and bureaucratic. Thus, for example, in site1 their procedure for agreeing to fund a business case for the small scale provision of a local service currently involves four separate steps, including: initial consideration by a senior GP/manager to see if the proposed service is a reasonable idea; more detailed assessment by an expert in the field; discussion of the detailed proposal by the Council of Members; final discussion and decision by the Governing Body. Whilst this may seem reasonable on paper, and certainly demonstrates membership engagement with the process, we know from previous research (Coleman et al 2009; Checkland et al 2011) that complicated 'sign off' processes for service developments are de-motivating for both GPs and managers, and that, in practice, even in the most streamlined of organisations, the involvement of four administrative steps such as this is likely to cause significant delays, with associated frustrations.

Other sites continued to struggle with the meaning of 'ownership' throughout the study. In Site 6, their initial approach had been to have the Council of Members driving the decision making process. However, as time went on and the task became more complicated, it was recognised that they would need an executive group to make decisions, using the Council of Members to inform those decisions:

> So the [Council of Members] meeting, the bi-monthly one where we had everybody come along, that is now trying, I suppose, to get everybody on board with the decisions, and certainly to discuss everything, and to feed into the decision-making process so they won't actually make the decisions, but their views, everybody's view there, are really crucial. Because otherwise if we go without them, it's going to be a nightmare, isn't it? And we need the views. Views need to be aired; we need to try and get a consensus amongst all systems, and they feel ownership of it. [Manager ID 41]

The key question here and in other sites was how far the governing body was the servant of the wider membership. This GP felt that they should be:

> We call it the executive, the government is beginning to talk about it as being the board and, ultimately, it seems that the clinical commissioning groups will actually, that will be the decision making group. At the moment we would say that the executives are the servants of the [council of members].[GP ID 33]

However, this manager saw it slightly differently, arguing that the Council of Members had given the executive the power to make decisions, upon which the wider membership could then comment, rather than the wider membership owning the decisions:

> Yes, that… I suppose that really is they have given the exec team responsibility decide, you know, that direction and the plan, so your first signoff is with the exec team, but then you take it to the wider group to say this is what we're going to take forward to see what we can develop, you know, what do you want to do, so ***it's just really exposing it to the wider remit as a sort of communication exercise really***, but also it's their then chance to say you're all barking up the wrong tree; this is not right, that sort of thing [Manager ID 42]

.

Each of the three sites discussed in this section so far were relatively small. In the larger sites the question of 'ownership' of the CCG did not arise in the same way, and there was much less effort made to get the active engagement of member practices in making decisions. Decisions were made by the executive group, and ratified by members meetings, rather than the members being actively asked to contribute. In one of the larger sites it was explicitly argued that the grassroots GPs had explicitly passed authority to make decisions upwards to the Governing Body and the Executive:

> What the guidance shows is that you've got a membership organisation which will reserve certain functions to itself and delegate others, which is not something I'd anticipated, but they're talking about the membership delegating certain things. Delegating doesn't seem to be the right word, but delegating to the [Governing body], who in turn will delegate to the [Executive]. Or, indeed, the membership might delegate some to the [executive] and some to the [Governing Body]. That's not been determined. I see, you know, that's a technical thing, that the membership will put the responsibility for these different things to the different bodies.[Manager ID 60]

In one of the other sites, a more formal proposal was made as to what the membership would be responsible for:

> Governance and Committee structure – It was proposed that the [all practice meeting] be renamed the [Council of Members] in the future as reflect better its role. This council would be responsible for issues such as: approving the constitution, standing orders, election of the Chair of the CCG, recommending commissioning priorities etc. The group would meet in private (ie not a public meeting) biannually or quarterly if deemed necessary with the Chief Operating Officer and Finance Officer present. Voting would be by single majority vote (named lead or deputy) and 60% of people will need to be present for decisions to stand. It is for this membership council to decide what they delegate to the governing body (CCG Board) and what to reserve for itself. [Chair] suggested that if we get this right and agreed it will set the right tone for operating the CCG. No questions were raised [Extract from fieldnotes GP members meeting February 2012 M16]

However, although this sounds relatively straightforward in principle, in practice there were tensions. In particular, CCGs see themselves as having a role in the performance management of their constituent practices, at least with respect to things which affect the commissioning budget, such as prescribing and referrals. In a Governing Body meeting at the same site the following exchange was observed, illustrating the tension between wanting to both engage and be in a position to challenge the membership:

> [Lay member ID 112] Great idea to refresh this and have consultation with the GPs but you must not just bow to what they want and like, need to do what the CCG Board wants – they need to be challenged. [GP ID 102] confirmed that this would be the case. We need to try to engage GPs but they will also be stretched otherwise there is no point to doing this work.[Extract from fieldnotes meeting January 2011 M1]

All of our sites expressed the belief that undertaking some kind of performance management of practices with respect to commissioning would be a key part of their role, and that it should be managed by setting up an agreement between the practices and the CCG:

> Accountability [point 7 in the draft framework]
> They were discussing about changing the bullet points 7 to 6 to make the document flows better.
> There's a point about performance management. One of the GPs commented that the term 'performance management' sounds negative and that they can't manage commissioning without managing practices.
> GP2: the only way to influence GP behaviour is by hitting their pocket.
> PCT1: Need SLA between practices and CCG in the future where there's issue about practice's referrals.
> GP5: If we are rewarding good practice then we'll also have to say what happens if they don't adhere.[Extract from fieldnotes, Governing body meeting September 2011 M13]

This GP, however, pointed out the problems with this:

> Q: Are there any mechanisms to ensure that practices are adhering to any policies of the CCG?
> A: This is the really tricky one. It's a membership organisation, and supposedly they have responsibility to the CCG. The LMC, I know, will say that in fact there's no contractual mechanism by which you can enforce practices to adhere to any of these things, and the LMC are advising practices not to sign constitutions that require them to explain their performance to the CCG..[GP ID 8]

In summary, whilst there was an aspiration (especially in the smaller CCGs) that the wider membership should 'own' the CCG, it remains unclear what this will mean in practice. Larger CCGs were less concerned with this issue, seeing the wider membership's role as to be informed about and to ratify decisions made by the Executive or Assurance level group.

3.4.2 Communication

Communication with the members was seen as an important task by all of our sites. Modes of communication that exist in most or all of our case study sites include the following:

- Newsletters or briefings sent round to all GPs
- Intranet accessible to all practices
- Locality meetings attended by practice representatives
- Meetings to which all GPs were invited
- Meetings to which practice representatives were invited
- Workshops on specific clinical topics
- Educational meetings
- Involving individual GPs in commissioning work streams

In one site the meetings to which all GPs were invited held part of the meeting in private, with no managers present, as it was felt that this would enable the GPs to speak out more freely. In this site they also initially set up a 'buddying' system, by which a GP closely involved with the CCG

would be 'buddied' with other GPs who were less involved, with the idea that they would keep in close contact and feedback developments. However, it was later said that this had 'fallen by the wayside'. Finally, in a small number of sites members of the Governing Body or the Executive would go out to meet with practices individually. Others acknowledged that this would be ideal, but it was regarded as impractical in anything but the smallest CCGs.

The key distinction we found across our sites was whether 'communication' was regarded as a one way or a two way process. In general, the larger sites tended to see it simply as a means of informing the membership what was happening, At the other extreme in some of the smaller sites there was significant emphasis on finding ways of engaging the members and getting them to contribute to the strategic direction of the group, with real two way communication between grassroots and executive or governing body. In between, we found a number of groups that, whilst not proposing that the grassroots members should lead the agenda, were anxious to find ways to gather and make use of the collective intelligence represented by GPs who see patients every day:

> And actually then you've got evidence to go back to your providers to say, well, you tell us this but our GPs on the ground tell us this. And I think it's important that we engage with GP colleagues that there's a, sort of, flowing of information.[GP ID 7]

In summary, therefore, the case studies suggest that attitudes to communication between grassroots GPs and the CCG as a whole fall along a continuum between:

- Those groups which see the key task as getting the grassroots to contribute ideas and strategic direction. These tend to be the smaller groups
- Those groups that see the strategic role as falling to the governing body, but which want to gather from their grassroots GPs intelligence that can be of use in the commissioning process
- Those groups which see the key task as being disseminating to the grassroots GPs information about what the CCG is doing.

3.4.3 The role of Localities

Five out of our eight case study sites have formal Locality groups in place. In four of these, the Localities act as the main membership forums, with meetings of the whole group intermittent or organised as a one off to discuss particular issues. One site has both a locality structure and an active Council of Members. This proportion is in keeping with the wider population of the CCGs, with 80/114 (70%) web survey respondents reporting that they have geographical Locality groups.

Overall, we found two distinct types of Localities in the case studies. Firstly, three of our sites had longstanding Practice-based Commissioning locality groups, which were incorporated into the CCG as it developed. These groups had long-established ways of working, and tended to continue much as they had done in the past, undertaking a mix of work relating to the CCG and other collective activity such as educational events or audit work. Secondly, two of our sites initially set themselves up as standalone CCGs, but decided to merge with neighbouring groups to form larger CCGs. The original CCGs were then incorporated into the larger group as 'Local Commissioning Groups'. These latter told us that they aspired to continue to do as much of the real work of commissioning locally as they could:

> [GP ID 231] said that his concern is local ownership, he doesn't want this to be a PCT all over again and so local ownership is the real challenge. He has tried to show the division of work between the large and the local group. As he sees it, the big group will be largely bureaucratic. There will have to be a name change, [original CCG] will have to be a LCG (local commissioning group) rather than a CCG. [GP ID 231] said that he hoped that this "would help us define what we are

> what we are doing". He asked if everyone was happy with this. [Extract from fieldnotes Locality meeting December 2011 M17]
>
> ….we still want to use the new CCG as a vehicle for federating three strong localities, we don't want to literally merge, we want to keep the three localities running separately as much as possible.…Basically we will just use the merged CCG to hold statutory accountability….and to risk share between the three localities, the balancing of the books will be based on one set of books at the statutory federated level, which is called the CCG. But really we will hold three localities individually accountable, so we'll have three sets of sub books [GP ID 251].

In practice, however, in both of these sites it became clear over time that the Locality groups were losing responsibility for many of the important CCG functions. One of the groups which stated its intention to remain as a 'strong locality' within the larger group actually held no meetings for several months; each time a meeting was due it was cancelled. This Practice manager expressed his anxieties in an interview:

> Will things ... who are going to be the local commissioners ... versus who are the federation level commissioners and what, what's the mechanism of that. …Because I feel that there's a danger that everything will just go to the federation, because all the key players are going to be there ... so you could take a view of what what's the point of locality commissioners as well, are we not just doubling up the work ….There's a danger perhaps that we've dabbled locally and it's worked really well but then in a blink of an eye everything's just going to be chucked up to the top again and it'll be back to big scale commissioning.[Practice manager ID 220]

In the other group there appeared to be something of a disconnect between the new larger group and the existing localities, with little mention of the wider group in locality meetings, and no clear decisions about what would be devolved and what would be done at CCG level. In both of these sites it remains unclear (as at May 2012) how the aspiration to maintain local autonomy will play out in practice.

A number of respondents across all of the groups which had a Locality structure told us that they intended to have 'strong localities'. This was usually described as a means of maintaining grassroots engagement, but in spite of repeatedly asking the question, the research team found it very difficult to pin down what a 'strong locality' is and what it might do. In the largest site, we were given a number of different accounts of the work and role of localities, with different respondents expressing different views as to how things might work. In this site it was argued that localities could not be allowed to work autonomously, and that they would only be given access to a small amount of money:

> Um, we're giving each locality a small budget just to do small things themselves. I think in terms of just setting stuff up for their locality, I think it needs…it does still probably need to go back to the [governing body] in terms of, well, actually, is it in line with, effectively, the overall CCG strategy, because we don't want one locality setting up, you know, a care at home service, and this one setting up a care somewhere else type service, so we want to try and get a more uniformed approach, um, but at the same time, we want each locality to feel as if, actually, you know, we can direct what we're doing, and how it operates here and manages here, but I think it would be on a case by case basis….so it's not going to be uniform, but um, I wouldn't say they're going to have total autonomy as a locality, because I just don't think it'll work. [Manager ID 55]

It is clear from these quotes that in this site it was not regarded as feasible for localities to have real commissioning responsibility. However, one of the other large sites took a completely different approach, delegating specific and significant commissioning responsibilities to localities, along with a significant devolved budget which could be spent up to a certain limit without reference to the wider group. Furthermore, the Localities have devolved responsibility for contract management with their local providers. This was articulated in an all-members meeting:

> They don't want to have a big central hierarchy - must have a supportive infrastructure but that all commissioning effectively takes place in the localities and so organisation must be built on the localities. There shouldn't be a one size fits all organisation. Members and localities have their own agendas and 80% of the resources need to be in the localities. The CCG needs to be a bottom up, not a top down organisation.[Extract from fieldnotes All members meeting January 2012 M18]

Other sites expressed an aspiration to delegate more, but it was sometimes argued that localities were not ready for the responsibility. One of the key factors which seemed to influence how much real work could or should be delegated to the Localities was staffing. Undertaking significant amounts of commissioning work at a locality level requires management and commissioning staff, and many of our sites told us that they were unable to afford this within the running costs of £25/head. The one site which did devolve a significant amount of money and work to Localities was, towards the end of the fieldwork period, considering merging Locality management support in order to be able to maintain staffing.

Overall, we found the following types of activity undertaken in Locality meetings across our sites:

- Activities designed to increase members engagement, such as information sharing and discussion of CCG development
- Discussion of particular clinical pathways and services. This work often moved beyond commissioning and focused upon educational topics such as audit data and improving primary care
- Collection of local intelligence about issues and problems with local providers
- Discussion of practice-level performance data

In addition, in a number of sites the Locality chairs sit as GP members on the CCG Governing Body. We found some lack of clarity as to how far these GPs saw themselves as representing the views of their locality and how far they saw themselves as representing the CCG to the locality GPs.

In summary, the role, status and function of Localities remain issues which are yet to be clarified across our case studies. In particular, it is unclear how much autonomy they will have, whether they will have delegated budgets and what their role will be in setting the overall strategy of the organisation. This is a particular issue in those sites which undertook a merger with neighbouring CCGs. In order to explore this further, this issue was followed up in the qualitative telephone interviews. Respondents were asked whether they had Localities, and asked to explain what their role is. As at July 2012, 20 of the telephone respondents said their developing CCG had Localities, 16 said they didn't (many stating they were too small) and two were yet to decide. Of the 20 with Localities, only three said that there was some limited delegation of budget, and five said that there was some limited delegation of commissioning functions. Other stated Locality functions included:

- Engagement (14/20)
- Collecting local intelligence (5/20)
- To supply board members (5/20)
- To develop pathways / proposals / services locally (4/20)

3.4.4 Performance management of practices

All of our case study sites saw the management of practice performance with respect to aspects practice impacting upon commissioning as part of their role. This included performance against commissioning budgets, referral behaviour and prescribing costs. Whilst official documents refer to 'improving quality' in primary care, most of our respondents were happy to talk explicitly about performance management. We saw the following means used in this regard:

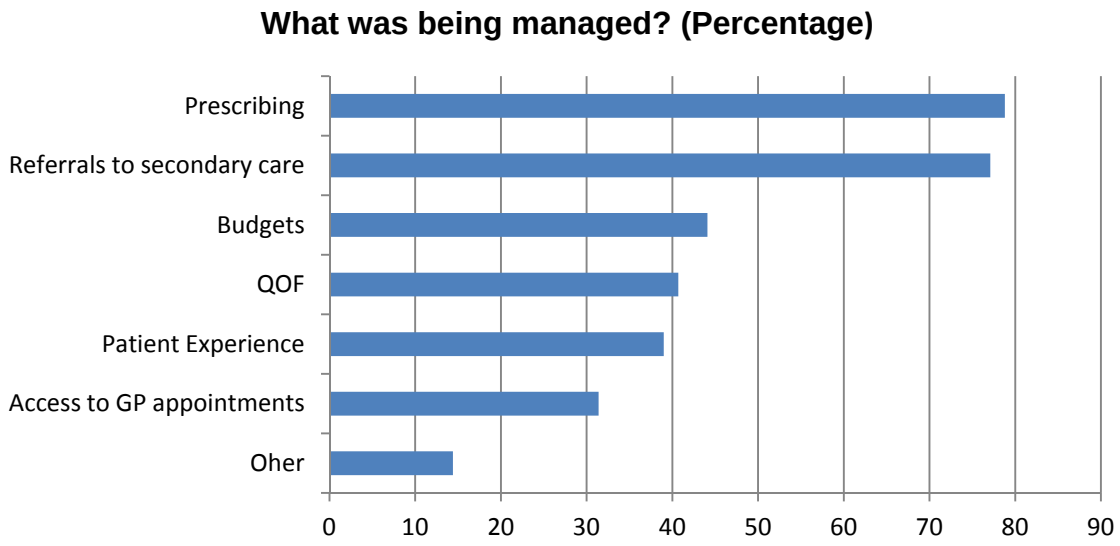
- Sharing of named referral performance data (all sites)
- Sharing of named prescribing performance data (all sites)
- Sharing of named data detailing performance against budgets (some sites)
- Referral management centre scrutinising all GP referrals (one site)
- Incentive schemes designed to target and improve performance (some sites)
- Visits to individual practices to discuss performance (some sites)
- Discussions of audit data in all practice meetings (some sites)
- Creation of intranet (dashboard) where data can be shared between practices (some sites)
- 'Buddying' poorly performing practices with those doing better for support and guidance (one site).

None of this was new to CCGs: in all sites performance management activities such as these had been running prior to the development of the CCG, usually under the auspices of PBC. Indeed, the development of effective mechanisms for the peer review of performance was regarded as an important strength of PBC (Coleman et al 2011). However, some people told us that they were concerned that such performance review and management would be more difficult in future as they had fewer staff to do the work; in particular, visiting practices individually is very labour intensive and may not be possible. In addition, as discussed earlier, there was some tension felt between the desire to be a 'bottom up' organisation led by its members and the perceived need to performance manage those members. In order to manage this tension most groups intended to concentrate on the presentation of comparative data to drive performance improvement, at least initially, although many also indicated the need for escalation should performance not improve:

> [manager ID 114] thanked them for a very clear report and asked if it had been shared with prescribing leads – no.
> There was a brief discussion on a particularly poor performing practice (in rural locality) and what should be done.
> [manager ID 114] suggested practices should be told that in the next few months this data would be shared publicly (warning to improve) peer pressure often works in these circumstances.
> [GP ID 104] Need to be careful how we use this data – could alienate practices.
> [Manager ID 114] Level 1 visits are supportive and then can escalate. [Extract from fieldnotes from Executive meeting November 2011 M19]

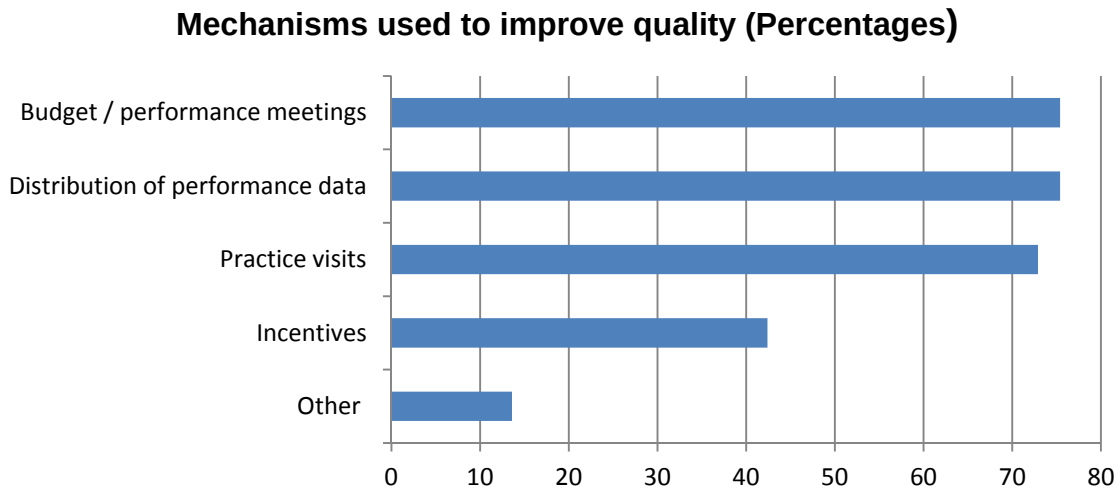
We asked about quality improvement in the second survey (May 2012) and CCGs told us that the following were areas that were being managed – see Figure 15 below. It can be seen that, even though GMS contract management will be the responsibility of the NHS Commissioning Board, 40% of CCGs are actively looking at the Quality and Outcomes Framework (QOF) as part of their quality improvement activities.

Figure 15: Quality improvement activities



We also asked in the survey what mechanisms were being used to manage activities. Three quarters were using budget / performance meetings (75.4%) and the distribution of performance data (75.4%), with slightly fewer carrying out practice visits (72.9%) as shown in the figure below. Only 42% reported incentive schemes; this is in contrast to PBC, under which all groups had active incentive schemes (Coleman et al 2009). The 'other' category included education events, pathway development events, peer review and, in one CCG, differential investment of resource across the CCG.

Figure 16: Quality improvement mechanisms



Some sites told us that they were concerned about the division of responsibilities between CCGs and the new NHS Commissioning Board.:

> [GP ID 103] This is important for all GPs and they need to buy into this at an early stage. Need to take care not to disengage them. Need to be clear what happens when good / poor practice is detected. [Manager ID 114] added that we will need to keep an eye on performance management as it is not yet clear whose role this

will be eventually the CCGs or the NHSCB? [Extract from fieldnotes Governing Body meeting January 2012 M1]

This concern was reinforced in the telephone interviews, in which 7 of the telephone interviewees told us that one of their key concerns for the future was the lack of clarity surrounding the future management of the GMS primary care contract and the division of responsibilities between the NHS Commissioning Board and CCGs.

Key findings: Being a membership organisation

- Some smaller CCGs are working hard to ensure that their organisations are 'owned' by their members, with the members setting the agenda and driving strategy as well as holding the Governing Body to account
- In larger CCGs we did not see this, with the relationship conceptualised in terms of the membership selecting the Governing Body to do this work for them
- Communication with the membership is seen as important by all CCGs, but what this means is seen differently by different groups.
    - Some see communication as predominantly a one way process, focused upon 'informing' the membership
    - Some see communication as a limited two way process, with the emphasis upon both informing the membership and capturing 'usable intelligence' from the clinical front line
    - Some see communication as a full two way process, focused upon capturing the views of the membership to set the direction of the group as well as on keeping them informed
- The role, purpose and remit of Locality groups remains unclear in all but one of our case study sites, and this finding is backed up by intelligence from the telephone interviews. This is particularly an issue in those groups which have merged. In particular, there is lack of clarity over the extent to which Locality groups should have responsibility for budgets and for commissioning decisions.
- Performance management with regard to commissioning is regarded as a legitimate role for CCGs, and this builds upon work that was already underway in all sites. The survey suggests that some CCGs also see themselves as having a role in managing aspects of the GMS contract such as QOF. There is evidence from some of the case studies that the move to CCGs has somewhat reduced the level of performance management being undertaken, in part due to lack of staff and in part due to a concern to avoid alienating CCG members. There is a potential tension between the desire to be a meaningful membership organisation and the need to manage performance. There is some concern over the lack of clarity surrounding the future management of the GMS contract and the role of CCGs in this.

3.5 The development of emerging CCG external relationships

Developing CCGs exist within complex and rapidly changing health economies. One of their key tasks over the past year has been to start developing those crucial external relationships which will play a part in determining their overall effectiveness in the longer term. In this section we will provide an overview of these developing relationships and the issues that have arisen.

3.5.1 Engaging with the Local Authority

PCTs have worked closely with Local Authorities (LAs) for many years, in particular undertaking joint commissioning for those conditions that require joined-up working across health and social care. Maintaining and building on these longstanding relationships has been a key task for developing CCGs.:

> The PCT has had a good relationship with the local authority, so I think, you know, there's an acceptance that there needs to be more joint commissioning… at that last meeting which you would have attended, it was agreed to the merging of the local authority.. re-enablement team and the PCT team …that looks after patients when they've been discharged, so actually it's merging those two teams, so it's actually going to be a joined up commissioned service or provided service and that obviously went through with support..[LA manager ID 6]

A number of different approaches to developing these important partnerships have been adopted in our case study sites. These have included:

- *Having LA members either as formal Governing body members, or as observers* regularly attending board meetings/other committee meetings. Overall, 3 out of 8 case study sites had an LA representative attending meetings of the Governing Body. In the April web survey, 8/118 respondents reported an LA Councillor on their Governing Body, whilst 35/118 reported a representative from Social Care. This LA social services manager described her role thus:

  > I mean, I think one is about - it's fairly straightforward -representing the Local Authority and helping the, kind of, developing CCG with its understanding of what the role of the Local Authority is…. so it's, kind of, representing the Local Authority, but it's also about being around the table as a partner, trying to shape what is really a joint agenda going forward. So I do see myself around the table as someone who is… you know, whilst I won't be someone who's making clinical commissioning decisions, so I won't be a, you know, a GP making those clinical commissioning decisions, but actually the whole intention of the Bill and… is that actually there is a much better integration across Health and Social Care, and we're making decisions in a joined up way. .….so it's not just about, kind of, being around the table informing, it is about trying to influence and shape the agenda. [LA Manager ID 6]

- *Having joint appointments*, with commissioning and managerial staff working across the boundary. In one site this was being taken further, with the development of a joint commissioning support team and an agreement to co-locate many CCG functions in the LA buildings. However, there was some concern that this might not be allowed.

- *Having joint committees* to commission across the health/social care boundary. In general these committees were longstanding, and the key concern with the reorganisation was to ensure that the joint working patterns established should not be lost. In some sites these joint committees had set up workshops to facilitate future joint working due to their evolving membership.

- *Working together on joint programmes*.

The two most important factors that appeared to enable successful joint working across our case study sites were the existence of pre-existing good relationships, and the ability of key individuals to bring things together. However, there were a number of concerns. Firstly, there was some evidence that the disruption associated with the reorganisation of the NHS (as well as local political changes) had retarded progress towards integration:

> Actually part of my remit when I first arrived was to develop and further progress our partnerships with the NHS, so it's been my agenda for a while before the CCG developments. Prior to that we were working very actively between ourselves and [local PCT] to actually implement some integrated commissioning arrangements, and in fact, we'd even got to the point of having PCT Board and LA agreement to move forward with an integrated commissioning structure across the Council and PCT. So there'd been a lot of activity locally already in developing our integrated commissioning arrangements, but obviously once there was the change of government nationally, there was also a change of administration locally. And we took the view at the time that it would be wrong at that point to push ahead with implementing changes when actually, you know, Andrew Lansley was signalling actually we doing a big shift here. And so really… so we are now with the CCG looking at, well actually, this is where we'd got to, how do we make sure in a new partnership arrangement with a new… with the CCG, how do we look at trying to build on some of the good work that had already happened, and actually how do we make sure we still deliver some of the benefits that that original plan was intended to deliver? [LA manager ID 6]

There was concern across all our sites to ensure that key responsibilities such as safeguarding children would not be lost sight of in this disruption.

Secondly, some felt that the LA had been too directive in their approach to CCG development, in particular in opposing the establishment of CCGs that crossed LA boundaries, hampering the development of new relationships.

Thirdly, some were concerned that the budget cuts affecting LAs could have a negative effect on the system as a whole::

> You know, there's been some excellent joint working, but you know, they've got their own issues around budgets, around elected members, which mean that, you know, and some of the understanding of, um, you know, they will say, your plan completely puts us at financial risk. [Manager ID 3]

However, in spite of these difficulties, there was a clear understanding across all our sites that working closely with the LA to develop more integrated services was essential:

> I think you have to negotiate very carefully the framework of what it is you're trying to achieve with the Local Authority, but if you do that, that also gives you better economies of scale as well and then you can survive, the small area who could integrate and work very closely with the Local Authority can survive. If it just stood on its own, it wouldn't really stand a chance.[Manager ID 9]

Key findings: Relationships with the Local Authority

- Most legacy PCTs had well developed systems for working with their Local Authorities
- Only a minority of CCGs are at present planning to have LA representatives on their Governing Bodies
- Some sites are keen to develop even closer relationships by, for example, co-locating or sharing commissioning support staff. However, there is some lack of clarity as to whether or not these initiatives are allowed
- Good pre-existing relationships and pro-active individuals are the most important enablers of effective partnership working
- The comprehensive nature of the current reorganisation has generated concerns about disruption to existing partnership working such as safeguarding and existing joint commissioning
- Some CCGs found their LA to be too directive in the early stages when they were developing their local configuration
- Some CCGs are concerned that LA budget cuts will impact negatively on their ability to work together
- There is a general recognition that closer integration between health and social care is vital if services are to be maintained

3.5.2 Interactions with Health and Well Being Boards

Health and Well Being Boards (H&WB) are currently being established across England in parallel with the development of CCGs. Whilst there was an initial aspiration that CCGs should only cross LA boundaries in exceptional circumstances where they could demonstrate clear patient benefit, in practice three of our case study CCGs crossed these boundaries. In the national web survey, 100/117 (85%) CCGs told us that they relate to a single H&WB, 15/117 (13%) relate to two H&WB and 2/117 (2%) relate to three or more H&WB. In our case study sites we found a significant amount of variation in the stage of development of H&WB, with some up and running well, whilst others had barely met once or twice. This project has collected a considerable amount of data about the early stages of H&WB development, but that is not the focus of this report. In this section, therefore, we will discuss the issues as they have appeared and affected the CCGs in our case study sites.

Early stages of development

Some H&WB in our study sites have established themselves up as new bodies from scratch. Others have adapted existing structures such as Local Area Partnerships, intending to build on the existing strong relationships:

> So we had members from the local authority and non-executive directors, including the chairman, from the two PCTs that sat down once every three months with, so your local authority and the PCT sitting down once every three months with the PEC chairs and looking at the strategy, and the director of child welfare, health and social care. That is a Health and Well Being Board by a different name, so we were already doing it. And what we've done is to change the joint commissioning boards into Health and Well Being Boards with a wider remit. So we've taken time, we've talked about the best way of doing it.[Manager ID3]

One of the key issues for our sites was to decide who would represent the CCG on the H&WB. In most cases this was a GP, although in some sites a manager attended as well. In general there were one or two GP representatives from each CCG on each H&WB. In one site the H&WB decided that a manager could not attend to represent the CCG, stipulating that the representative

had to be a GP. This caused some issues for the GPs, who felt that they were short of time. One issue in this regard is the frequency of meetings: H&WB in our sites vary considerably in how often they meet, with some planning to meet monthly, whilst others will meet quarterly. Obviously it is much easier for a GP to take time out to attend a quarterly meeting than it is to meet more often. In another site the HWBB wanted representation from 2 GPs, however the CCG didn't agree to this due to lack of clinical time. A compromise was reached with one GP and one lay member attending but this caused some difficulties especially at the outset and currently only one GP now attends. Those sites relating to more than one H&WB had double the number of meetings to attend, which is an issue in terms of capacity for busy GPs. In one site the CCG was leading the development of the H&WB, with the CCG Chair also appointed to Chair the H&WB.

We saw evidence of CCGs and H&WB beginning to work together to tackle the following areas:

- Safeguarding
- Integrated care
- Adult & Children social services
- Acute care
- Disability
- Vulnerable people
- Dementia
- Health inequalities

<u>Concerns and issues</u>

A number of concerns and issues were expressed in our case study sites:

- *Concern about demarcation of responsibilities and duplication of work*. It remains unclear at the present time exactly how CCGs and H&WB will work together, particularly in relation to strategy development and the redistribution of responsibilities. There is particular concern about the fact that H&WB are intended to have an oversight role in the development of commissioning plans, but without any means to enforce change:

  Well the health and well being board has got, and nobody can work out how this is going to work, they've got overall responsibility for the well being bit, which is their bit really, and that would be everything from public health that's going to transfer to them, and some of the projects that have come under health now will go with them to the health and well being agenda and there will be everything like housing and education and transport, because they all do that bit. But they hold to account the clinical commissioning groups who are doing the health bit, but they've no teeth around that. ….and this is what elected members struggle with, ' we can hold them to account but what does it mean, we've no teeth, we've no sanctions or anything. We can't say "We're going to strip you of being a CCG" and so on, we can just open up the debate about it'.[Lay member ID 284]

- *The need to reflect local issues and concerns*. H&WB sit at the upper tier of Local Authorities. In larger counties this can mean that they cover very large areas, with a number of District Councils within that.

  It works if you've got a single-tier authority, but of course we've got dual-tier; and a lot, particular in terms of health and wellbeing and public health stuff, a lot of those responsibilities actually sit in terms of environmental health and all those other [things] sit at district level. So it's all very well having a county-wide mechanism but actually unless you're working also with your district council you can't actually deliver [Manager ID 205]

In order to meet this concern, one of our case study sites was exploring the possibility of developing local H&WB groups which could feed in to the larger Board.

- *The need to understand different ways of working,* and to bridge the gap between different understandings about the nature of the task ahead. This also included the need to address the simple practical issues to do with how the new bodies will actually function on a day to day basis

- *Concerns about the impact of local politics*. A number of respondents commented that the strategic direction of the LA could change if the council changed its political make up.

In addition to these general concerns which arose across all of the sites, three of our case study CCGs have the particular issue of relating to more than one H&WB. This caused a number of problems, including duplication and different ways of doing things::

> The two personalities of the Local Authorities, the two ways of...unfortunately they've got...there's one Acute Trust but there'll be two community providers and two sets of social care teams. And two ways of doing things, and actually how do you get integrated care from all those strains. It's a massive challenge.[Manager ID 224]

.
Finally, there was considerable uncertainty and concern across all of our sites as to how Public Health (PH) would work in the new system. This CCG were keen to 'embed' PH in their work before it moved to the LA:

> [GP ID 282] We are clear we want PH involvement in commissioning. In future PH will be employed by LA and we won't have budget for PH. If we embed it with us now then LA can't take it away from us. PH embedded somewhere at Board level. We agreed on this. The difficulty is the actual person [Extract from fieldnotes Governing Body meeting December 2011 M26]

Others were concerned about the financing of the new PH system:

> Well, I've talked about, you know, splitting out the budgets, splitting out, you know, the public health element and that budget is going to be really troublesome and we're a long way from agreeing that, we're a long way and, that, although, you'd say, in some ways, well, that doesn't impact on the CCG, but, it does, you know, it definitely does. So, there's a long way to run on that.[Manager ID 115]

Overall, at the time of writing this report, the future relationship between CCGs and Public Health remains an outstanding issue in most of our case study sites.

<u>Factors affecting the development of CCG-H&WB relationships</u>

We identified a number of common factors which appeared to influence the development of CCG-H&WB partnerships. As with the development of CCGs as a whole, many respondents told us that the roles of individuals were crucial. In particular, it was important to have 'strong representation' from CCGs on the local H&WB, and the personality and style of the LA leaders could have a significant impact. Being able (or unable) to attend meetings was also important. In these early stages it is clear that both parties are finding it difficult to make sure that the appropriate people attend the different types of meetings:

> A councillor from the HWBB said that he felt very marginalised and frustrated. They want to be involved in CCG strategic planning but struggling to get in or only

> brought in at the end of the project. The facilitator responded that issues with HWBB will be fixed in the statutory board [Extract from fieldnotes from Organisational and Stakeholder development meeting November 2011 M24]
>
> But I'm actually struggling a bit with that at the moment. I've sent a couple of e-mails saying I'd like to come to this and that and I'm not being invited. I've commented on the odd paper and sent it back, but I don't feel involved. I don't feel part of that and I'm the GP Lead for Obesity. So I think - and maybe I just need to work harder at it. I don't know.[GP ID 103]

Sometimes, the timing of meetings could be an issue, with GPs, for example, finding it difficult to attend meetings on Fridays, which is always a busy day in practices. H&WB in our study sites varied as to the balance between elected councilors and LA officers on the board, and this could significantly influence the dynamics involved. Finally, a number of our sites ran joint development sessions involving the CCG and the H&WB, and these were useful in allowing all parties to clarify their respective roles and responsibilities.

Key findings: Relationships with Shadow Health and Well Being Boards

- Health and Well Being Boards are in different stages of development across our case study sites
- Some have started to build new organisations from scratch, whereas others have made small adjustments to existing bodies to meet the requirements
- There are still some uncertainties about how CCGs and H&WBs will work together. In particular, there are concerns about:
  - The exact demarcation of responsibilities
  - Maintaining a local focus in those areas with a two tier LA
  - Different ways of working
  - The number of meetings GPs sitting on H&WBs will be required to attend
  - The impact of politics, particularly if a Council changes hands
  - The lack of formal powers for either CCGs or H&WBs to influence the work done by the other
- Working across LA boundaries brings with it particular issues
- There are widespread concerns as to how Public Health will function in the new system
- Joint development sessions are valuable

3.5.3 Involvement of patients and the public

All of our case study sites expressed a commitment to genuine involvement of patients and the public in their work. Many included such a commitment in their statement of their 'vision' or 'mission', and were keen to demonstrate a new approach:

> No, absolutely. I mean, the other thing, probably, just the stress, because, it's been a bit of a journey for us, you know, us thinking that if we really want patients, at the heart of what we do, then, people leading on, how do we reach out to the communities, the individuals, both, through the practices, through any, you know, having that patient and public engagement, we felt that, in the PCT, it was, almost, over here, as a, kind of, tick box part of the organisation, whereas, us, trying to bring that into mainstream and whatever piece of work we do, putting it through the

> lens of, well, from your perspective, how do we reach the customers we need to, has been really important [Manager ID 114]

Engaging with patients and the public was seen as a 'good' in and of itself, but many respondents also gave clear explanations of the value added by true public engagement. This manager had spent some time considering the issue, and explained it thus:

> Well, I think there's four reasons you do public engagement, and that's what I worked out in this study. One is, **you need to know whether things are happening, right**. Secondly, **you've got to be aware of public needs, public feelings** for the commissioning process that you decide what you're going to do. … Then you've got to…you've then got to, to some extent, have a two-way liaison because you…sometimes if you're trying to pursue policies that need people to change their behaviour, **you've got to take people with you**. Now if you're going to close a facility, you've got to explain it. You don't close it and afterwards say well, you've got…no, what they tend to do at the moment is say we're going to close this, what do you think, and they will say no. You have to come and say look, we have this hospital and this hospital, and that's too much capacity, what are we going to do, you know? Hard to do that, but that's what you've got to do. That's the third thing really, sort of taking people with you. And if you want people to change their behaviour about eating and all that sort of thing, you've got to do it. And the fourth one I think is long term caring, long term conditions. **You've got to involve people much more in that, you know, supporting people who have long term conditions**. So that's four reasons, that's it.[Manager ID 263]

This GP also felt that it was important to demonstrate accountability to the public:

> I think what we haven't done yet and what we're trying to organise now in this locality is go one step further and recognise that we are after all accountable to the public, we're there to serve them, we are paid by them, we're there to provide their health needs. So actually it only makes sense to actually be in discussion and contact with them and this has been a long sought after chalice to have, you get public engagement made meaningful in the Health Service and no-one's ever done it successfully in my view.[GP ID 200]

In general, our sites were keen to embed engagement with the public deeply within their organisations. One of the sites has established a time-limited patient reference group to develop an over-arching strategy to integrate PPI into all that they do. The purpose of the group is to "monitor the implementation of the principles and, in consultation with local stakeholders, develop a communications and engagement strategy". The group comprised of CCG lay member for PPI, representative from council of members, senior manager from PPE team, LINk/Healthwatch representative, voluntary sector representatives, PPG Support Network representative (which is currently managed by LINk), and Local authority representative.

Overall, local Healthwatch has been slow to develop in our case study sites, and the involvement of existing LINks is variable. We saw a wide range of different approaches and initiatives to engage with both patients and the public, some planned and some already established, with many sites planning to use more than one approach. These included:

- *Local patient forums* – either generic, or for specific patient groups
- *Patient participation groups at individual practice level*. Many case study CCGs were looking at ways to bring these groups together to provide wider intelligence about local services

- *Community involvement groups*, bringing together representatives from carers organisations, voluntary sector groups, and patients. In some areas these types of groups were constituted as a subgroup of the CCG
- *Steering group* – one CCG had set up a 'steering group' which brought together PCT Cluster representatives with LINks members, carers' representatives, voluntary groups, local clinical networks etc. This group met periodically and offered advice and comment to the CCG governing body
- *Clinical reference groups*. These are usually set up jointly with local Acute Trusts, and generally focus upon particular service areas such as diabetes etc
- *Stakeholder group*. This is a group of local patients and the public who are asked to comment on proposed major service changes
- *Public events*. For example, one of our case study sites was planning a series of 'road shows' in supermarket car parks which would offer health checks as well as providing information about the development of the CCG
- *Citizens panel*. This is a group of interested individuals specifically convened to discuss in depth a proposed service development
- *Patient experience network*. This is a network which focuses upon the collation of patient experiences of different types of health care, including both primary and secondary care.
- *Newsletter*. At least one site was planning a public-facing newsletter
- *CCG Board open public meeting*. After authorisation, all CCGs will be required to hold some of their Governing Body meetings in public. Many are starting to do this all ready, reasoning that it would be good practice to begin to get used to this. Some were holding alternate monthly meetings in public, using the other internal meetings to work on organisational development.

It is important to note that many/most of these types of public engagement event/process were in place as part of the local PCT's work or the PBC group which was in existence before. Many groups told us that they were keen to develop more effective public/patient engagement than had been achieved by PCTs in the past, but in this pre-authorisation phase we have not yet seen any active initiatives that are significantly different than those which had gone before. For example, in one of our sites they had set up their board meetings in 'public' in such a way that members of the public who attended were only able to ask any questions that they had at the beginning. After that, no further questions were allowed. In an interview we were told:

> I don't know why they've set it up this way to be honest. I haven't been involved in that, so I don't know what the rationale is. **I've got a feeling that was how the PCT used to operate**, but I might be wrong. I mean I think if we're trying to engage with our public, but only allow them to speak at the beginning, before we've actually said anything…it does rather go against the ethos, I think! [Manager ID 122](emphasis added)

It is widely acknowledged that effective public engagement is difficult to achieve, and our case study sites wrestled with many of the issues that research into PPI have identified in the past. Firstly, whilst there is widespread recognition that individual patient voices are important, it is also important that those appointed to forums or engagement groups see themselves as representing the wider community as well as feeding in their own experiences. Where wider engagement activities are attempted, it remains difficult to access those whose voices are not usually heard Some tried to tackle this by engaging with existing patient and voluntary groups. However, this can also be difficult, as there are a myriad of such groups, many of which have diverging agendas. Secondly, in some sites we found some concern as to which different aspects of the CCG's work could most usefully seek engagement. Whilst many remained committed to engaging the public in all aspects of the CCGs work, others argued that commissioning and the strategic aspects of service change were actually not of interest to the public.

> NHS organisations come and go with such incredible regularity that the public in fact don't give a stuff and I don't blame them. …I don't suppose anybody on the street realises that the PCT is going and the CCG is being formed because. So it's no point engaging people about stuff like that because they don't care. We have accountability and we will tell people but actually most people don't care. What they really care about is what's happening to my local hospital? Is my experience good or bad? Or are you planning to change something and how is that going to affect me? And I think engaging people in those things in the planning of their care, working with groups of people who are affected by change, building trust with communities over time, we've got a tremendous track record. [Manager ID 244]

Key findings: relationships with patients and the public

- Patient and public engagement is something which all of our case study sites were committed to, with many aiming to engage patients/the public in as many aspects of their work as possible.
- Most are building on existing PPI structures and processes, but would like to embed the concept more deeply in what they do.
- They continue to wrestle with familiar PPI issues, such as who is a valid 'representative, and in which aspects of the commissioning process can PPI be most effective/have legitimacy

3.5.4 Working with neighbouring emerging CCGs

Many of our case study CCGs are in the process of developing both formal and informal links with their neighbouring groups. Formal links include: sharing senior leadership posts (in 2 sites, including Chief Financial Officer and Accountable Officer); sharing commissioning and managerial support (outside the developing CSS); developing shared commissioning programmes; and appointing clinical leads for some topics who would have the remit to work across the district. Many were also developing informal links, often fostered by attending networking and other meetings. Ideas were shared and common problems identified. Finally, we also encountered some emerging country-wide associations of CCGs who see themselves as having a common agenda. We identified a number of factors which CCGs identified as pushing them to collaborate in this way. These included:

- To have a much stronger position when negotiating with secondary care providers
- To share resources and allow greater flexibility around funding
- To enable CCGs to commission services for less common conditions
- To avoid duplication of work
- To develop a 'critical mass' of like-minded CCGs who will have a national presence and be able to lobby on behalf of CCGs

One CCG which was planning to share their finance officer with a neighbouring CCG also planned to share associated audit functions:

> So to do that three times across [neighbouring CCGs] is silly, isn't it? And that's the other thing, we might need to think about: do we have some share in governance and risk and things like that. And it might be that you don't, because obviously [local CCG] as a health system probably could have its own, but there are some things that you don't want to do three times. But if I have a shared

> finance team and I have shared financial systems I will try and have one audit committee across rather than three audit committees [Manager ID 287]

However, another CCG in the same position did not believe that this would be possible:

> Each will have its own statutory duty to break even and duty to provide this assurance to its own board. So you will need… you might be able to share some, but, actually, because you're not a statutory body jointly, more than likely you're going to have to, unfortunately, do it separately. You're going to have to have different… you're going to have to have separate auditors to audit your accounts or twice as many There is… there would be savings if it was a single CCG. Unfortunately, because it's two separate entities, there are some costs.[Manager ID 43]

Some concerns were expressed about working across boundaries in this way. In particular, CCGs were concerned to work with groups that both shared similar issues and had a shared perception of what they were trying to achieve:

> Actually there's a lot of similarity between what they want and what we want, and I think we're quite similar in lots of ways and maybe have, sort of, similar populations, and we're a better fit, I think, with [neighbouring CCG] than we would be with the other [local CCGs]. And there seems to be a world of difference between east [county] and west [county]. So you know whilst I think it's good to make links with people over in the west, we're in a completely different place [Manager ID 36]

Some told us that they were concerned that their neighbouring CCGs were less advanced in their development, and therefore not ready to collaborate fully. Others acknowledged that the relationship could be difficult:

> I've been to a couple of meetings where there's been [neighbouring CCG] representation there. The concern has been that obviously they have a different agenda to us in that they don't see the issues that we see in [local area] and that they feel that we're draining their resources, because any service that we have in [local area] takes away from the services that they have at [their area]. So there's a competitive edge there….So it's early days and I have to say there is this concern that they have a different agenda and a different wish list to us.[GP ID 199]

There was some evidence that historical issues such as these could be overcome as CCGs worked together to solve joint problems.

Overall, we found that good relationships were enabled by: a history of successful joint working in the past under previous types of clinical commissioning; significant shared past history such as being part of the same administrative grouping (eg PCG); and individuals who were able to make links between organisations. It was also important to have clarity around joint working arrangements, with, for example, clear Memoranda of Understandings which set out responsibilities and roles.

Key findings: relationships with neighbouring CCGs

- All of our case study sites recognise the importance of working with their neighbours
- Both formal and informal collaborations are under development, building upon past 'lead commissioner' arrangements
- It is not yet entirely clear how sharing personnel between different statutory bodies will work in practice, in particular we found differing opinions as to whether shared posts would also allow sharing of other statutory functions such as audit
- At present CCGs are more likely to be sharing resources with those that they regard as 'like-minded' and who are perceived to be facing similar problems
- Working together to deal with practical problems can help to overcome suspicions and foster good relationships

3.5.5 Relationships with major providers

Aspects of commissioning and contracting will be discussed in more detail in section 3.6 of this report. However, a number of issues arose in our case studies regarding interactions with providers.

Overall, GPs in our case study sites were becoming more engaged with the practical aspects of commissioning, including attending commissioning and contracting meetings. This is regarded as a significant strength of the new system, and some told us that the development of CCGs provided a moment of opportunity in which they could redefine their relationships with providers. However, some expressed dissatisfaction that hospitals were not yet reciprocating and sending clinicians to meetings:

> I would say [relationships with providers] weren't too bad; but what I would say is there's a need for more clinical involvement from providers.
> Q: Right. So there's clinical involvement from this side but not the equivalent from the provider side?
> A: Not always, no. I suppose where I'm coming from there is what we tried to do is make our contracts clinically led; I'm not so sure that's the philosophy in provider trusts.[Manager ID 202]

Where provider clinicians **were** involved (or had been in the past), there was concern that Trust managers were trying to exert more influence:

> My concern is more with [new community trust] in that...you may have heard this already, we did have a very good working relationship with clinicians because obviously they were employed by the PCT previously. Now that they've gone to [community trust] it feels as if the management of the partnership trust are actually stopping them from engaging with us. So whereas we were having regular meetings with them and designing services together and having...well, any service that we were developing with them we'd have regular meetings to see how it was performing and try and address any issues that we could between us, though a lot of those conversations have now stopped. And it feels like people are being stopped from engaging with us, they're basically being told by management; you can't speak to the commissioner about this. So it's a huge backward step. [GP ID 199]

Historically, there has been a tendency for large Trusts to seek to dominate the commissioning agenda, deciding what they want to provide rather than engaging with commissioners. Some are hopeful that CCGs will be able to make a difference to this:

> I think at the moment it's the perception in [local area] is that actually the providers, the main provider just doesn't get their relationship and that, you know, actually they are a provider, we buy their services and therefore we're the customer rather than the historic arrangement of they tell us what to do and what services they're going to put in place and so there's a little bit of tension, a bit infighting around that at the moment. It's not, you know, beyond the point of not being told, but it's them just understanding that dynamic and that it is going to change and the GPs will be moved, won't be dictated to quite as much as a consultant, you know, and how is that going to work and that sort of thing [Manager ID 42]

There was also a concern in some sites, that, in common with previous forms of clinical commissioning (Coleman et al 2009), powerful Foundation Trusts were acting in ways that were against the interests of CCGs by, for example, up coding / miscoding activity.

Key findings: Relationships with providers

- Developing CCGs are clear that engaging productively with their local providers will be vital
- There are some concerns about managerial dominance of providers and the strength of large Foundation Trusts

3.5.6 Other developing external relationships

The case study CCGs were in the process of developing their relationships with a number of other stakeholders and professional groups. This process has been complicated by the fact that some of these other organisations are undergoing reorganisation at the same time as the NHS is being substantially reorganised. The most prominent additional external relationships that we observed included:

- **Existing local involvement organisations**. Local involvement networks (LINks) are currently in the process of being incorporated into new bodies called 'Local Healthwatch'. These are still very much in the early stages of development, and we found varying views as to how the relationship should develop, particularly in view of the fact that Local Healthwatch' will have something of a scrutiny role.

  > [Healthwatch] is sort of tooling up. It's not, doesn't exist as a function in this part of the world. I was interested to note that [local] LINk, which is sort of what seems to be merging into Healthwatch, were saying that they were going to be demanding a place on the governing body of each CCG and demand a representative ….and we all feel that, actually, that's not appropriate. GP ID 33]

  In other areas they were formally involved with a (non-voting) place on the Governing Body. However, a concern expressed by one LINk/ Shadow Healthwatch's representative was that since they were there in attendance and do not have a vote, their presence may be viewed as an agreement to the CCG's piece of work or proposal:

  > We don't have a vote, so we can only make comments. One of the things actually I'm about to suggest to the December meeting is that actually the LINk/shadow Healthwatch involvement in meetings is actually more formally recorded, because I think there's an expectation with our community that because LINk is sitting at the commissioning committee, we're deeply involved in it and I think that sometimes

there's… well, we know it's happening, but because we're sitting at a meeting and a piece of work or a proposal is agreed by the clinical commissioning committee, therefore we have agreed it. And that's not necessarily the case because we don't have a vote. [Lay member ID 5]

- **Community pharmacy**. Pharmacists had a formal role as members of the Professional Executive Committee (PEC) of PCTs. However, there is no formal role for them in CCGs: in future Community Pharmacy will be commissioned by the NHSCB and will be part of local networks on which CCGs can draw for advice. At the time of doing the research these networks had not yet been developed, and this community pharmacist voiced concern, arguing that pharmacy needed to be closely involved with CCG development :

  [Pharmacist]- It's difficult to visualise how pharmacy will fit into the grander scheme of things. The future of GP practice and pharmacy is linked (each influence the other). I think pharmacy have a role to play in supporting practice. So want to attend[CCG], contribute and know what is going on.
  [Chief exec of Local Pharmacy Committee]- There are 46 odd community pharmacists in the area. Always had a good relationship with the PCT and GP colleagues. Woke up one day and that was all gone. As far as GP colleagues were concerned we were isolated. I had a meeting with [GP ID 4] to discuss this. In a new CCG era- all avenues to communication are closed. When I met [GP ID 4] talked about 2-way communication. Whatever money there is needs to be used really well. Medicine optimisation is needed. GPs spend a lot on medicines. So we need a forum to work closely with our colleagues. Locality groups are morphing into the CCG so want to be involved in strategy and implementation.[Extract from fieldnotes GP members meeting February 2012 M27]

  However, there were others who did not think it was really appropriate to have community pharmacy attending CCG meetings, and it may be that the new networks will answer these concerns.

- **Local Medical Committees (LMCs)** are representative committees comprised of elected members from local practices. Historically, PCTs have liaised with LMCs about important changes to primary care services or contracts. In some of our CCG case studies, the LMC have been quite heavily involved some of the CCG's decision making process for examples in drawing up their constitution document. However, their role and legitimacy to carry out this role is not clear:

  [GP]: There's power imbalance between LMC and us as small CCG having to account to them.
  [Lay member]: They said leaner and sharper but then asked for 12 meetings. That's ridiculous.
  [GP]: We'll liaise with LMC as we see as appropriate.
  [other GP]: Should LMC be invited back to the Exec Board meeting?
  [GP]: They don't need to be invited. They can just turn out.
  [Lay member]: They are currently asking PCT to account to them on your behalf as [GP]. Now you are coming directly as GPs, you are the accountable body so they have no role to hold you to account.
  [GP]: So we cross out 'monthly'. Of course we'll meet regularly with appropriate people. [Extract from fieldnotes Governing Body meeting Sept ember 2011 M13]

  Even though LMCs have no formal role in the new system, some were concerned that if their views were not taken into account this would undermine the support of GP members for the work of the CCG, particularly in the area of improving the quality of primary care::

> [GP ID 165] We were attempting to build a model to improve the quality of primary care but need to be pragmatic and practical. If we go against LMC, practices may become disillusioned we should go for the simple this time and go more complex next year.
> Executive accepted this and the new version was to be circulated.[Extract from fieldnotes Locality meeting March 2012 M28]

Overall, the role of the LMC with relation to CCGs remains to be fully worked out. Prior to the current reorganisation, LMCs represented the views of local GPs and would negotiate with PCTs about any issues that affected general practice. Whilst LMCs will still clearly have a role in making representations to the NHS Commissioning Board about issues affecting general practice contracts etc it is far less clear what their role will be in relation to CCGs, which are membership organisations themselves. If some GPs have issues to do with their CCG's activity, then there will be means by which this can be addressed within the constitution of the CCG, without the involvement of the LMC. It remains to be seen how this will develop in future.

- **The voluntary or third sector**. The CCGs in our case studies were aware of the need to involve the voluntary sector.

> We've had two quite big meetings with the voluntary sector, with GPs present, to talk about what's happening in the future, um, and we've got quite a useful action plan that's being developed around what the voluntary sector are looking for and, you know, what their information needs are, and kind of future engagement. So they're very involved. …Because the CCGs can see that they're quite important for going forward.[Lay member ID 66]

However, it remains early days, and we saw little actually activity in this area so far.

- **Allied Health Professionals (AHP).** Some of our case study sites had set up wider stakeholder groups in which the wider community of clinicians (such as AHP) could contribute. However, the role of such groups remains unclear, particularly in light of the development of 'Clinical senates' by the NHS Commissioning Board.

Concerns were expressed in many sites that, whist such engagement was recognised to be important, it was time consuming, and often involved additional meetings, which could be a heavy burden.

Key findings: Relationships with others

- CCG's external relationships are currently in a state of flux, with new partners getting to know one another
- Some CCGs see an opportunity and a chance to redefine relationships, particularly those with local providers
- Some existing local partnerships have been disrupted by the change, and it remains unclear how, for example, some local actors such as Community Pharmacists will contribute in the future
- Overall, the current reorganisation involves changes to many aspects of local health economies simultaneously. Many of these changes are occurring at different rates (eg CCGs are more developed than Local Heathwatch in most areas), and it will therefore be some time before the new relationships can be fully defined and functional.

3.6 Approaches to commissioning and contracting

In this section of the report we will discuss the approaches being taken to commissioning by our developing CCGs and by those who responded to the web survey.

3.6.1 What is being commissioned?

Setting priorities

To facilitate the process of commissioning most of the sites had been through some sort of prioritising process for commissioning intentions for the next 2-5 years. This often involved a series of meetings where potential priorities (identified from various sources such as the local health needs assessment (HNA), public health etc) were discussed and ultimately rated by those present (most often managers, GPs and other Board members), this was then translated into a set of priorities for the CCG moving forward, often set out in the CCG's developing strategic plan.

Such a process was described at a meeting as follows:

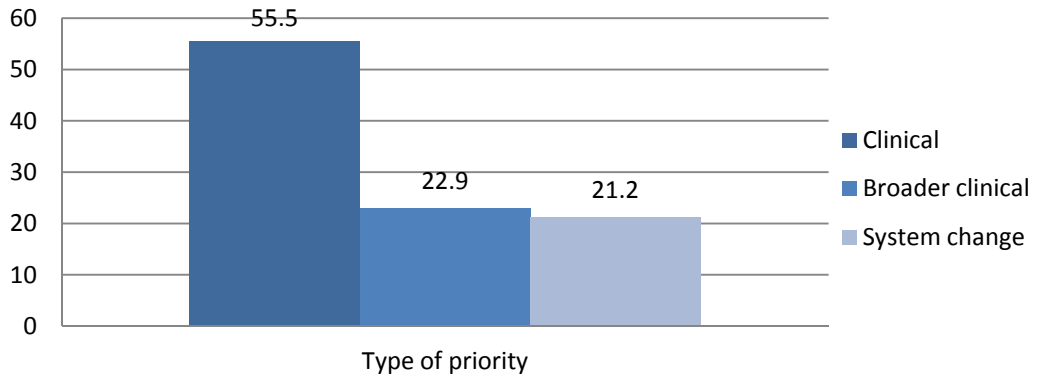
> Members were thanked for the submissions. The Chair asked members to prioritise commissioning intentions as high, medium or low to inform consortium. Returns to be handed in to [named person] at end of meeting. The HNA would be factored into the returns with the first report available at beginning of September. A more detailed report would be available mid September. It was highlighted to the consortium to be mindful of how much would be achievable – and what areas of similarity there would be between the consortiums which could inform the work programme more broadly [Extract from Members meeting minutes August 2011 M32]

One manager cautioned against getting distracted from these real priorities, explaining that if you are not careful you can spend time and energy on things which in the greater scheme of things are not key, suggesting the value of having an overall strategic plan:

> …instead of saying, "These are the things we need to do", we get distracted, there's some money over there for this thing, now that may not be one of our priorities but there's money there; you're just drawing off time and energy [Manager ID 205]

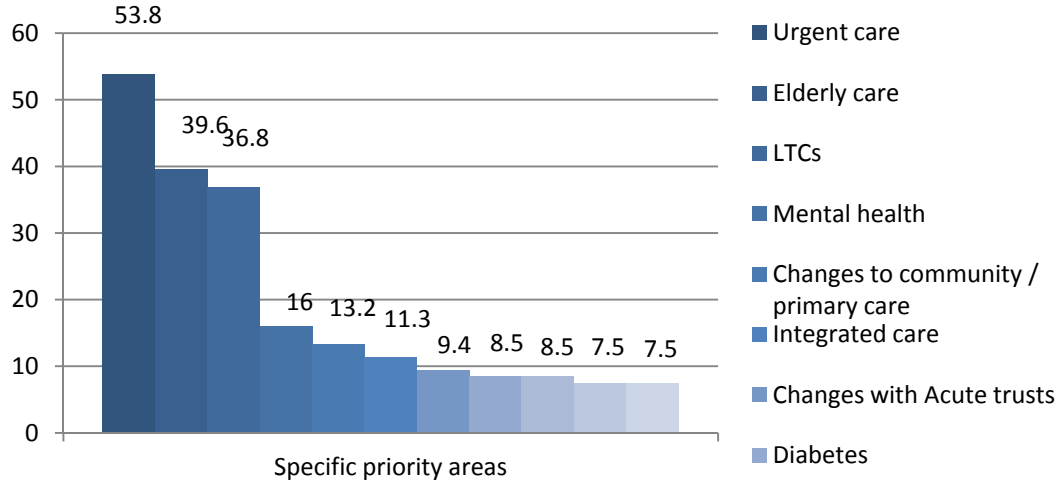
In the second survey we asked CCGs what the top three 'clinical' commissioning priorities were for them. Overall, 106 CCGs gave 318 answers which have been categorised in the graph below into clinical priorities, broader clinical priorities and system changes.

Figure 17: Percentage of responses in each category type (commissioning priorities)



In terms of specific priorities, over a half (57, 53.8%) of the CCGs included a priority associated with 'urgent care / 111 / unplanned care', two fifths (42, 39.6%) included 'care of the elderly / dementia / falls', a further 39 (36.8%) listed long term conditions (LTCs) and a sixth (17, 16%) had 'mental health as a priority. Further priorities are shown graphically below.

Figure 18: Percentage of CCGs giving each priority as one of their top three



Changes to services

We also asked in the second survey 'since becoming a pathfinder has your CCG set up or does it plan to set up any new services in the next year'. Of the 118 respondents to this question, three quarters (78, 74.3%) said yes. These services were very wide ranging (for example, services associated with specific disease groups such as diabetes, rheumatology etc to broader services in the community or associated with well-being) and the most common method for choosing the provider of the new service was through single tender action/uncontested procurement/service development.

CCGs were asked if they had changed or planned to change (in the next 12 months) any providers of existing services. Over two fifths (44, 42.7%) said that they had / did and the most common procedure for choosing a new provider was through competitive tender. We also asked if the CCG had or planned to (in the next 12 months) change / redesign any services without changing the current provider. Here the majority (87, 83.7%) said that this had happened already or was planned.

In many of the case studies, new services developed were initially run as short term pilot schemes or small local enhanced services to allow a period of evaluation before the scheme was rolled out across the patch and / or for a set contract period. In some sites there had been initial discussions on larger scale projects which were being developed but had not yet been implemented. For example in Site 6 an urgent care action plan was in development. This was seen as a larger scale strategy under development which would potentially drive a range of schemes locally once it was agreed.

> They discuss detailed urgent care commissioning plan
> [Manager ID 34]: I was able to say to cluster there is a plan in place which went down well as they are scrutinising finance and performance. Urgent care is now the major challenge for commissioners.
> [GP ID 36]: this is a good piece of work – should be sharing with GPs so they understand what is going on and can endorse it.
> [GP ID 33]: need more support from and engagement with public health and patients to ensure it is owned by the entire CCG as looks like being biggest piece of work [Extract from fieldnotes Executive meeting November 2011 M34]

In another of the sites there had been initial discussions around differential investment in primary care between localities. However, this was still at a relatively early stage and was yet to be agreed across the whole CCG area as illustrated in this exchange observed at a management meeting:

> [Manager ID 169] Yes it is in the financial plan and accounted for already- it will cover primary care, IM&T, long term condition as and extra investment for [named] locality. Need to treat this as pump priming money. It is dependant on SHA approval and we have to put forward business cases to get it back (2% of budget). We need to review and evaluate schemes.
> [Manager ID 171] We need to be strong and disinvest where money is not having an impact but we need the evidence for all our decisions.
> [Manager ID 166] I will be coming out to localities soon to discuss the issues with them. We need to look at non-recurrent money vs recurrent impacts.
> [Manager ID 176] Initial investment into [specified] area should be cash releasing in the longer term if things work how [GP ID 165] thinks they will. This can then be invested back into the [whole CCG] not just [specified locality].
> [Extract from fieldnotes Executive meeting March 2012 M13]

It is currently too soon to see the outcomes of changes to services and or providers that had taken place since the CCGs had started to emerge. Our case study sites told us that they were very aware that they needed to evaluate new service or schemes that were implemented. There was also recognition that changes would potentially impact on providers and that the whole health economy had to work better together. However, the current funding system (including Payment by Results) makes this difficult:

> [named scheme], if that saves money… We have no way at the moment I don't think of… I mean if [named scheme] worked, and we expanded that massively, and reduced… the idea would be to close hospital beds. But then the [named provider]'s income goes down, so they're not going to want that. So the way the whole structure is funded creates barriers to doing things more effectively, innovatively and for better value. I mean how do you change all that?
> Q:Yes. It's a huge challenge isn't it?
> A: Yeah. But I think… this consortium has made huge steps in doing things collaboratively and with the Trusts rather than us and them that culture is changing.

> The PCT it was the PCT versus the [named provider]. It was like a battle. People didn't get on. It was horrible [GP ID 103].

Decommissioning services

A third (31, 31.4%) of CCGs, responding to the second survey, told us that they had already or planned to (in the next 12 months) decommission some services. Most commonly the services were originally being provided by an acute care trust. From the case studies we also saw evidence of some decommissioning of services but this was mainly small in scale. For example,

> They have just decommissioned the GP led health centre at [named hospital] and reorganise the phlebotomy services as a result, so I guess that's probably the first major piece of work that they've done [Lay member ID 5].

A manager in the same site explained that clinical support was important to any decommissioning process:

> I think the GP-led health centre; decommissioning that. We wouldn't have got that through without clinical support [Manager ID 2].

In another site what they described as decommissioning was in reality a change to a service:

> we de-commissioned a [number of] acute medical beds, and then put in [a smaller number of] step up, step down beds. We de-commissioned the [a few] cardiac beds, and re-commissioned a stronger service at [named location]. I mean, de-commission is probably a strong word for it – we worked in conjunction with the acute provider, who led a lot of the changes, to try and cover the bases [Manager ID 204].

Sites also stressed the importance of an evidence base decision making process, often involving consultation with patients, when considering the scaling down / decommissioning /stopping of any service. Furthermore, there was a recognition in many sites that most of the current services had been established historically and would need to be reviewed as the CCG became more established as this manager describes:

> In this transition period we've got a lot of services that are, you know, historical services that have been in place that individual practices have put in place. Sometimes they're working really well; sometimes they're not working really well. What we've got to do really is sort of review all of those and then re-commission them in the new way of doing it sort of thing [Manager ID 42].

This was especially true where schemes had been put in place but never evaluated:

> Chair explained that when [GP ID 253] was on the PEC they had given [specified provider] the £72k to set up a pilot on interventional psychology. After the pilot the money just continued – largely because [specified] PCT had been abolished. This was more than 10 years ago. It was never evaluated and never rolled out. There was general discussion of how unsatisfactory this was [Extract from fieldnotes Executive meeting November 2011 M14]

3.6.2 Who is doing the commissioning?

We were keen to find out who was undertaking commissioning in each of our case study sites – was it the emerging CCG, localities within this or still being left to the PCT / PCT Cluster (as the

latter were still technically the responsible organisation) or a combination? In some of the sites the CCG was so focussed on organisational development that most commissioning and contracting was still being carried out by the PCT / PCT Cluster. In other sites it was clear that the emerging CCG (or at least managers working in the CCGs name, as opposed to the PCT) was being enabled and encouraged by the PCT cluster to carry out these functions. Here there were often quarterly Board to Board (PCT Cluster to CCG) meetings to help govern the process. In sites where localities had been long established under PBC (and in some cases where budgets were already historically devolved), some of the commissioning tasks were devolved to the localities. This often tended to be services / pathways which were to be redesigned or developed locally, piloted and rolled out across the CCG if they were found to be successful or as part of a newly developed local enhanced service (LES) which practices could sign up to.

In one site, despite allowing the emerging CCG significant autonomy, the PCT had (relatively recently) requested to attend future contract meetings. The CCG management team were not happy with this and the following discussion took place at an observed meeting:

> [Managers ID 114 and 116] The PCT cluster wants to come to our contract meetings with providers. It should be us managing the providers not them and we should be reporting back to them. Its our meeting. Suggestion from [manager ID 115] that the meeting should go ahead but in 2 parts – invite PCT cluster to first part and have the meat in part two when they have gone. GPs need to help decide how we respond to these requests [Extract from fieldnotes Executive meeting M36]

Where localities exist within the CCG area there were differences in the extent to which the localities took responsibility for developing schemes. In general most service change was driven by the higher level CCG with the exception of the sites where localities had been operating previously under PBC with devolved budgets / responsibilities.

There were some examples of tensions between levels such as PCTs and localities, where the PCT managers were driving commissioning and the localities (and individual GPs) being asked to implement things were not kept up to speed with developments so felt left out of the loop and not part of the service development. For example the following was observed at a locality meeting in one of the sites:

> [Discussing recommissioning of mental health service]
> [Manager ID 17]- basically says underway now- too late. Can have say in March when consultation document.
> PM asks- 'how is this GP commissioning?' talking therapies was supposed to be our first project. GPs struggling to see how they have had any input.
> [GP ID 8] says are 3 GPs on the committee. Others questioning how much power [another GP] and the other GPs have? He said if had really pushed for what the GPs wanted would have been a huge conflict. So not really feasible.
> GPs very frustrated- PCT come and ask for their comments but then they just ignore them. Lots of nodding, discontent. They just get given a package that they don't want. Want more holistic approach.
> [Extract from fieldnotes Locality meeting November M37]

There were also examples of schemes having been developed previously but only implemented through clinical commissioning:

> Q: would you say the psychological therapies, has that been an example of redesign?
> A:Yes. That, of course, hasn't been something that was redesigned through clinical commissioning! It's stuff that was on the shelf years ago. Actually that was

> just implementing something that had been on-going, and opportunistically using the vehicle of clinical commissioning to drive it faster. [GP ID 1]

Many of the sites acknowledged that they were currently in a transition phase with some commissioning work being carried out by the PCT cluster level and some by the CCG / locality levels. However, there was some evidence from the case studies that things were beginning to change in terms of who was leading the decisions to change services / service providers. Previously there had been a perception that changes were being driven from the provider side, but there is some hope that the increasing involvement of GP may have an impact here. For example, the following extract shows that providers will have to start to think about the process being driven more by the commissioners:

> So, what we need to do is pick our battles well. So, for instance we have already had the spinal services discussion, which we had before, and, a couple of trusts decided to work together, and they came along and said, great, okay. So, yes, specification's very interesting, but this is the service we're going to provide. Really? And then no, this is the specification. Yes, no, we know the specification. But actually, what you need to do is this and this. No. Had a long process, you know, to develop this, lots of consultation, all the rest of it. This is what we want, okay? So, you tender for this, or you don't tender. No. And so, when they didn't get it, they were gobsmacked [GP ID 64].

Emerging CCGs were very aware that come April 2013 they would be become the accountable body as was seen in a discussion at a management meeting at one of the sites:

> There is no longer going to be a PCT to pick up the pieces. We are going to have to hold each other to account (localities and GPs) and work hard at this. Localities need to own contracts. We have to look at financial credibility. We have an overall limit and only have the small transitional fund to fall back on. We need to be on top of things from quarter one and decided how we are going to monitor things [Extract from fieldnotes executive meeting March 2012 M30]

In many cases, GPs acknowledged that they were having to learn about the commissioning process and what was involved from experienced managers as this GP explains:

> So, currently, as we're heading towards authorisation and kind of emerging as a CCG, I'm just… I'm, kind of, working with the commissioners within the PCT that are there at the minute, just to, kind of, learn their roles and to be involved in projects that they're currently running [GP ID 37]

Despite this many of the GPs are becoming more involved in both commissioning and contracting meetings, as well as GP clinical leads being vey involved in the work of their established clinical work streams. This will be discussed further in the next section – GP added value.

3.6.3 Perceptions of GP 'added value' in commissioning

Participants from many of the case study sites told us that they felt that the involvement of GPs had 'added value' to both commissioning and contracting. Some emphasised the importance of clinician led commissioning as opposed to GP led commissioning, pointing out the value of partnership working between clinicians particularly across the primary and secondary care divide. We have seen GPs involved at the CCG level, as part of localities and as clinical leads. Managers value certain skills that are different to their own that can be brought to the table. For example:

> Its their clinical knowledge, isn't it that's the key. So I think they add value particularly in terms of the design of services… and understanding their patient's needs [Manager ID 9].

> for me it's really amazing to watch these clinicians leading change on a really significant scale, and it's very different to, I guess, what I thought might happen, after seeing those early stages of practice based commissioning, which were, you know, doing a little bit of dermatology in your practice, for other practices, it was very small scale [Manager ID 204].

From the perspective of GPs themselves, they told us that part of their value lies in the fact that they are on the 'frontline' of patient care. They claimed that, as GPs face the patient population on a daily basis, they know about and understand their problems and thus are best placed to represent their interests. They are also coming to realise that their new roles as GP commissioners will place them in the position of having to explain and justify commissioning decisions to their patients.

> The point still remains that GPs are probably the right people to do this, because the beauty of the fact that we have to sit across the table from the individual patient. And yes, we're not the most patient responsive bunch of people, but we still have to meet Mrs Jones, and she still gets to rant at us about the fact that her hip operation isn't being done. And it will be our ears that get bent if we get it wrong. Whereas that's not the case if you ask anybody else to commission. [GP ID 221]

Many managers appreciate the value and role that GPs are bringing to commissioning and believe that their functions on CCGs are complementary. In some sites they specifically talk about changes in tone and focus of such meetings. This manager talks about maximising the contribution of GPs, realising that their time is expensive and most work on commissioning part time. Utilising their skills at the most appropriate times is important:

> we have talked about this as a group, which is about how one appropriately makes sure that GPs add value and contribute at the, you know, the appropriate juncture, rather than as sort of a scattergun fashion, which, you know, may not be an appropriate use of the, you know, expertise and resources [Manager ID 62].

The managers below talks about the importance of team work and the corresponding skills that clinicians and managers bring to the task of commissioning, a task that is continuing to develop and evolve.

> There's no question whatsoever in my mind that the best change processes that I've been involved with… every single one of them without exception has been where I've been part of a clinically led managerially supported change process. Because that's when you really get benefits for patients. As a manager, as a lay person I know how to do things, but I'm not, as a clinician would be able, always to determine what to do. So you need that combination. You need the clinicians deciding what's going to really work, that needs to be rooted obviously in a really close understanding of what people want, and patients and service users want, and then you need people with the kind of expertise that I've got that can help to make it actually happen. And where you get those things working well together, it really gels. [Manager ID 244]

We asked the telephone respondents about their perception of GP added value in the new system, 18 mentioned benefits of having direct links with patients, 13 said the different perspective / clinical

view was important, 4 referred to having a holistic view of the system and 3 the ability to work with GP practices.

3.6.4 Perceptions of GP 'added value' in contracting

In the second survey, almost all CCGs (97, 96%) indicated that GPs and or practice managers attended contracting meetings with existing and / or prospective providers. A similar proportion (90, 88.2%) also attend contract monitoring meetings with existing providers (along with managers). Interviewees in the case study sites claimed that GP participation in contracting meetings made a substantial difference to negotiations. At such meetings it was suggested thatGPs are able to make the clinical case for commissioning or decommissioning services and they can do this with authority and confidence.

> we're beginning to see some successes in terms of GPs' involvement in some of the, some of the contracting rounds, so...They actually go along to the Contracting meetings. And, you know, and giving clinical view and clinical input around some of those discussions and conversations. And that can add real value in terms, for both the providers and the commissioners, to really start driving forwards some of those tricky conversations [Manager ID 54].

The GP contribution in contracting negotiations was often cited as an important indicator of CCG success to date. Many interviewed felt that the clinical presence around the negotiating table had obliged providers to change and to realise that CCGs are about to have a strong influence on future contracting. They also felt that clinician peer to peer contact had led to better and more constructive relationships.

> They're [providers] upping their game; that they know they can't get away and what they need is a provider to be serving their needs and making sure services do deliver. They know the spotlight's on them and that GPs are coming. [Manager ID 2]

3.6.5 Other clinician value

The fact that GPs and other clinicians are able to make clinical contributions to the commissioning process was valued. In two of the sites a wider advisory group was in operation (see section 3.1.4). Here a manager describes its function and the value it adds to the commissioning process in one of the sites:

> I mean I can tell you what the kind of responsibilities are for… it's more of a discussion table. It's not really about decision-making. So it's… looking at clinical advice and guidance, things like the NICE-type stuff that comes out. And looking at the new drugs and formulary, that sort of thing, strategies and development of plans, key area of priority work streams, Some things like the diagnostics, looking at diabetes, and all those sort of areas that are high cost areas and redesign. So also it provides a mechanism for clinical and organisational engagement [Manager ID 159]

In sites 5 and 8 groups of professionals such as nurses and allied health professionals hold monthly meetings where issues around commissioning are discussed and fed back into the commissioning process. In addition, in sites 1, 3, 5, 7 and 8 work streams have been established that focus on clinical matters, commissioning for specific areas and issues concerning quality. Work that had been previously undertaken at PCT level around referral management and prescribing management is now on the agenda for CCGs. Interviews and observations pointed to increased clinical engagement with these issues and the importance of clinical peer interaction for the success of these activities.

> I think if the managers had said we want to use the Oxford Hip and Knee Score, we wouldn't have got very far. It's the GPs in the clinical commissioning programme that have said these outcomes don't look very good, we need to do something and the right thing to do is to use a tried and tested method for measuring whether people need a hip. So it's the clinicians that have said to the GPs you need to use it, and the GPs are referring to [it]. [Manager ID 59]

3.6.6 GP commissioning: Problems

As discussed in section 3.2.5, the merger and federation of CCGs has created some difficulties and challenges. Among these is the issue of where, within newly merged or federated organisations, commissioning takes place. This question highlights the tension between wanting to create organisations that are sensitive and responsive to local needs and exercising economies of scale. Groups that had initiated the process to become CCGs and now found themselves to be localities within larger CCGs, were concerned that their local commissioning ability and focus could be lost within the larger organisation. Discussion and debate about the level of commissioning that is appropriate and possible within localities is ongoing.

> Q:When the CCG gets authorised, will localities have their budgets to commission things they want?
> A:Probably not, no. I think we'll still do that as a total CCG. … So I think the reality is, it'll be similar to what it is now, but we'd hope to get more local ownership at the locality level, saying, well, what's working for you, what's not working, what do you want us to take back to the contract monitoring? How do you want to change things? Is there anything that could be done at your locality level? But we just need to be careful that we don't think that they're totally autonomous localities, because they're not. [Manager ID 55]

Another area of difficulty concerns the time constraints faced by GP commissioners. While clinicians were generally enthusiastic and positive about their contribution to the commissioning process, they were worried about the time commitment involved. The argument that GPs understand the needs and requirements of their patients is based on the fact that they regularly interact with patients. Many GPs involved in CCG work felt that the pressure and volume of this work took them away from their 'day job' potentially jeopardising their patient centred focus. In other words, it is difficult to find time to be a GP commissioner which also discourages 'rank and file' clinicians from becoming involved with formal CCG work. Some of those interviewed felt that they were not able fulfil either their GP role or their commissioner role to the best of their ability.

> There just isn't the time to do it. … So, I always feel I've never quite done it properly because I haven't had quite enough time to read anything, and I haven't had quite enough time to think about what I want on the agenda for the next meeting, and it's already there, and the papers have to go out, like, today, for next week. The papers have to go out, and I haven't had much chance to influence them. [GP ID 8]

> And I spent yesterday, six hours in a Joint Strategic Needs Assessment on the Health and Well-being Board, for which I have not been paid, and I won't get paid. That's why I am still catching up on my clinical work, and I came in at 7 o'clock this morning to do all my paperwork and spent till 8 o'clock last night doing that. So I spend hours and hours of unpaid work. So I maybe do two days a week, and this is sometimes in my own time or my free time -- doing the work that needs to be done. [GP ID 218]

As GPs shoulder new responsibilities as commissioners their patients and colleagues may see less of them which is potentially problematic. In addition, GPs are also realising that this new role

will mean that they shoulder responsibility and accountability for commissioning decisions. The fact that they will be held to account and possibly blamed for future unpopular commissioning fills some with unease.

> I think, we'll have a chance to develop some services and that'll be clinician led, and that's good, but, I think, we'll be faced, before very long, with disinvestment decisions, which won't be good and we'll be paying for and will alienate us from our colleagues, who never want to face the reality, we'll have to lose some services. You know, we're only at the start of the efficiency savings we're meant to and, I think, you know, trying to keep the service together, over the next five years is going to be really, really hard and, I think, if you can't have the carrot of small scale local improvements to keep you motivated, you're not going to be wanting to be around for the other stuff. [GP ID 184]

Similarly in those sites that serve a diverse population where there are distinct income and health inequalities, commissioners are beginning to grapple with ways in which they can address these inequalities. The distribution of budgets according to principles of equity and fair shares may also raise future difficulties and tensions for commissioners.

> The fair shares debate that you heard some of was, was a strong reflection of that, and I think caught between their desire to do the right thing and the difficulty pragmatically of being able to shift the money around - because it's not that easy. And I think that's some of the frustration that you're seeing from the guys, that…well, you're trying to do that with almost level funding; the only way you can do it is to take money off somebody and give it to somebody else, and the difficulty of doing that is, immense, clearly. [Manager ID 171]

Key findings: Commissioning

- Most sites had been through some sort of prioritisation process for commissioning, which ultimately were included in their ongoing strategic plan.
- In the survey three quarters of CCGs had already, or planned to, set up new services in the next 12 months and two fifths had changed or planned to change some providers of existing services.
- Most changes to services to date had been small in scale, short term pilots or linked to local enhanced services or innovation funding and only small scale decommissioning had occurred if at all.
- Commissioning was taking place at all levels - the PCT cluster, CCG and / or localities where they existed. The level at which this occurred was dependent on history, local relationships and changes to CCG configuration.
- Commissioning was in a state transition and tensions could be seen between the various levels of organisation in some sites.
- Many of the sites could point to instances of added value in both the commissioning and contracting processes due to having clinicians (most commonly GPs) involved.
- The GP contribution in contracting negotiations was often cited as an important indicator of CCG success to date.
- Difficulties in commissioning were seen where CCGs had recently merged, were caused by time constraints faced by GP commissioners, and GPs are also realising that their new role will mean shouldering greater responsibility and accountability for commissioning decisions

4 Discussion

In this report we have attempted answer the following research questions:

- What have been the experiences of Pathfinder CCGs over the past year?
- What factors have affected their progress and development?
- What approaches have they taken to:
    - Being a membership organisation?
    - Developing external relationships?
    - Commissioning and contracting?
- What lessons can be learned for their future development and support needs?

In this discussion, we will draw through and discuss the major themes that emerged from the data, and relate these to existing evidence.

It is first perhaps useful to set out what we did not find in this study. We found no obvious differences in attitudes between GPs and the managers with whom they were working. Whilst both brought their different experiences and perspectives to bear on the issues they faced, in general their primary identification seemed to be with their locale not their professional group. Attitudes, ways of working and priorities were therefore more a product of the local context than they were of the professional background of those involved. Even those managers whose future job prospects were insecure appeared to identify with the developing CCG with which they were working. Secondly, we found no difference between the different 'waves' of Pathfinder CCGs. Those who applied to be Pathfinders in wave one were not systematically different from those who applied later, except perhaps in their disappointment that the early promise of being able to influence the policy process had not been fulfilled. Thirdly, although size is obviously an issue with respect to the relationships between the CCG and the wider population of GPs, we saw no other systematic differences between large and small CCGs. Finally, although the initial permissive approach to CCG development has generated considerable diversity on the ground in terms of structures, we found a general convergence between our sites in terms of key issues and approaches. The factors affecting development in our case study sites were common across the sites, and the findings are confirmed by responses to the web survey and telephone interviews. We therefore believe that, in spite of the apparent diversity on the ground, this study provides evidence relevant to the wider population of CCGs.

4.1 Birth to authorisation: experiences of Pathfinder CCGs of the journey so far

Our data show that:

- In general, newly set up CCGs initially mirrored existing or past institutional boundaries. Longstanding local relationships, trust and historical experiences were key in this process. This mirrors previous developments in primary care commissioning such as PBC (Coleman, Checkland et al. 2010).
- Previous experiences led participants to believe that 'early adopter' status would bring with it benefits. However, benefits expected by early wave Pathfinders did not generally materialise, largely because the programme quickly became universal
- The development process in up to 25% of sites was disrupted by mergers, which were not always welcome to those involved
- Throughout the development process participants perceived a tension between the promise of autonomy and the belief (often borne out in practice) that there would eventually be an official blueprint. Case study participants, web survey respondents and telephone interviewees all told us that they would have liked to have had clearer guidance available earlier on in the process.
- Throughout the development process there was continued change and development in structures and processes, with a number of case study sites introducing additional

organisational layers very late in the process as they responded to new guidance and external pressures. In many sites the exact roles and responsibilities of the different formal bodies remains unclear.

In all of the case study sites we found a willingness to engage and work with the changes. In some cases this was driven by genuine enthusiasm for GP involvement in commissioning; for those less enthusiastic there was a feeling that, as the changes were going to happen, it was necessary to engage in order to ensure that negative impact was avoided and that the changes were implemented with as little disruption as possible to the delivery of high quality patient care. Many of those involved had had experience of involvement in previous NHS reorganisations, and saw themselves as providing ongoing continuity for the system as a whole as it went through a period of significant change. This is congruent with findings from previous NHS changes (such as Fundholding and Total Purchasing Pilots), in which GPs have generally shown themselves to be willing to engage with commissioning (Coleshill, Goldie et al. 1998) (Wyke, Mays et al. 2003).

However this positive engagement came at a cost to individuals of their personal time, with many GPs and managers telling us that they were working long hours at weekends and in the evenings, and at a cost to the NHS as a whole, with many GPs attending large numbers of meetings for which reimbursement and locum payments were claimed, and which took them away from front-line patient care. In addition, significant amounts of managerial time were taken away from other routine work.

The most significant difficulty that developing CCGs found over the course of the last year is that many aspects of the NHS have been in a state of uncertainty at the same time. This has meant that many aspects of development (such as which staff they should employ) have had to be left in abeyance because they depend upon developments in other parts of the system.

Whilst overall there was an appetite for more and clearer guidance, the specific guidance issued relating to authorisation was generally found to be helpful. However, most developing CCGs identified early in the process individuals whom they wished to appoint as Accountable officers, and they were disconcerted to discover at a relatively late stage (April 2012) that such posts would be required to go out to open recruitment rather than simply appointing such preferred candidates as had been assessed as suitable by the national process. There were differing views as to whether it would be advantageous to be in an early or late wave for authorisation, with some concerned that later waves would have more requirements placed upon them, whilst others believed that early waves would be scrutinised more closely. The process of preparing for authorisation was found to be labour intensive, with some concerns that it was detracting from the core business of commissioning. The support received from PCT Clusters and SHA Clusters was generally welcomed.

4.2 Overall experiences of the Pathfinder approach

Our data show that:

- The Pathfinder process was a very effective way of generating momentum and achieving sign up for the development of CCGs
- Participants generally regarded becoming a Pathfinder as a ‘badge’ that they needed to achieve in order to gain credibility and to begin their development
- The early lack of clear guidance has been a particularly problematic issue for many groups
- In terms of practical support, national and regional meetings were regarded as helpful, especially those at which national leaders appeared. Other aspects of the Pathfinder programme (eg online forum and the Pathfinder learning network) were not prominent in our case study sites, and were rarely mentioned by survey respondents
- Opportunities to network with peers in meetings were valued

- Preparing for the authorisation process was extremely time consuming, but CCGs welcomed the clear guidance and support that they received during this process
- In general, the early promise that Pathfinder CCGs would be able to influence the overall direction of the policy was not felt to have been fulfilled. In particular, those who had signed up as Wave 1 Pathfinders felt that the extension of the programme to all groups had removed any influence that they might have had in the early stages
- There was a perceived disconnect between early encouragement to develop their own ways of doing things and an emerging sense that there was an official agenda which must be adhered to.

In terms of aspirations for future support:

- They wished to have access to named individuals from whom advice and support could be sought as and when needed
- There is a clear appetite amongst CCGs for the NHS Commissioning Board to avoid being too directive to CCGs, allowing them to develop and to respond to local needs with a minimum of central directives
- There is an emerging concern (mainly found in the telephone interviews, which were carried out at a later stage than the rest of the data collection) about the future management of the primary care GMS contract, with respondents asking for greater clarity as to how the distribution of responsibilities between CCGs and the NHS Commissioning Board will operate in practice.

It was the explicit intention of the Pathfinder process that the approach should be permissive, allowing CCGs to develop their own way of doing things. This has led to considerable diversity on the ground in terms of structures, but less diversity in terms of approaches and activities.

We have been asked to comment on both CCG's experiences of support over the past year and on their needs and aspirations of support for the future. In general, local support was valued more than that which was available nationally, except that those who had attended meetings at which national leaders appeared had found this to be helpful. In particular, receiving affirmation from those national leaders boosted morale and enthusiasm. SHA Clusters and PCT Clusters had both provided support, with the balance between these two varying from place to place. Many had also bought in external support, largely from management consultancies. CCGs did not generally see themselves as being recipients of any systematic programme of support, but rather as selecting support from a menu of options. The most problematic aspect of their development was the early lack of clear guidance, and some contradictory guidance, with SHA Clusters sometimes being more directive than the national guidance. The support available for the authorisation process was felt to be good.

In terms of future support and developments, our case study and survey respondents were not looking for any specific programme of support. They told us that they were keen for clearer guidance as to what is and is not 'allowed', and for the NHS Commissioning Board to adopt an 'arms' length' approach, allowing CCGs autonomy. There was some suggestion that they are concerned about the practicalities of interacting with the NHS Commissioning Board, and are anxious to have familiar faces to approach for help. In addition, some are concerned about the lack of clarity surrounding the primary care GMS contract, and would welcome a clear statement of respective responsibilities. In summary, therefore, they are looking for more clarity about the structures within which they will be working, but are keen to retain autonomy to develop as they see fit within these structures. Existing evidence shows that in the development of previous approaches to clinical commissioning, the extent to which the external environment was permissive was an important determinant of success in achieving objectives (Miller et al forthcoming).

Further research is required to follow the development of the CCG-NHS Commissioning Board relationship as both move forward from April 2013 as statutory bodies.

4.3 GPs as 'clinical leaders'

One of the key aspirations for the new system is that it is to be 'clinically led'. So far, these 'clinical leaders' are overwhelmingly GPs. Our data show that:

- The extent to which GPs initiated the move to CCGs varied from site to site, with some Pathfinder applications clearly developed by groups of GPs (usually existing PBC groups), whilst others were driven by PCTs.
- The extent to which GPs were leading the development of CCGs also varied from site to site, with some developing CCGs clearly 'owned' and led by GPs, whilst others were driven by managers, usually senior PCT managers/directors. The most common model we found was one of 'co-production', with senior managers and GPs working together to set up a new organisation. In this model, 'leadership' is vested in a key group of GPs and managers who work closely together.
- Good management support available locally is crucial. Even those GPs working in the most senior positions in the developing CCGs at most devote 1-2 days a week to the work (although many are also working in the evenings and at weekends). There is thus a need for managers on the ground who are able to deal with the day to day issues that arise, and provide continuity.
- GPs are used to working as owners of small businesses. As such they can make rapid decisions and have limited external accountability for those decisions. There is therefore a significant learning need for GPs as they come to terms with the requirements for governance and accountability associated with their new positions on a developing statutory body
- Most current GP leaders have held some sort of leadership role in the past, for example, in PCGs, as fundholders, as PBC leaders or as PEC members. There is a clear aspiration to introduce first time GP leaders, but only one of our sites has been successful in this so far. The key concerns here are both the need for succession planning and the need to engage with the wider population of GPs, including salaried and sessional GPs as well as partners. There is a gender imbalance, with female GPs underrepresented in leadership positions
- As one might expect, a relatively small number of GPs are actively engaged with the development of CCGs and their activities. They are keenly aware of the need to develop meaningful engagement with their member practices, and many are intending to do this via Locality groups. However, there remains significant lack of clarity over how this will work in practice, as CCGs have not yet decided how much autonomy Localities will be allowed.
- Our survey shows that just over 50% of CCGs who responded have an absolute majority of GPs on their Governing Body. Evidence from the case studies suggests that, in those areas where GPs do not form an absolute majority, many of the non-GP members will be non-voting.

Previous evidence on clinically led commissioning has shown that where clinical leaders have most autonomy, they are more likely to achieve their objectives. Furthermore, the achievement of those objectives acts to generate enthusiasm and commitment to the project (Miller et al, forthcoming). Whilst CCGs will control a far greater proportion of the Commissioning budget than any previous manifestation of clinically-led commissioning, it is not yet clear to what extent they will have autonomy over their commissioning decisions. Clarity over the roles and responsibilities of the different actors in the new system will be a key determinant of the extent to which clinical leaders are able to take control of the commissioning agenda. Furthermore, CCGs (unlike all previous manifestations of clinically-led commissioning), will be statutory bodies with associated accountability and governance responsibilities. This will act to limit GPs' ability to act quickly and autonomously, and it remains to be seen what effect this has on their enthusiasm and ability to achieve as commissioners.

Another key factor that may determine the extent to which GP leaders can control the agenda is the internal support and legitimacy that they enjoy. Research demonstrated that the development and maintenance of this legitimacy was a key determinant of the extent to which PBC was able to develop and thrive (Coleman, Checkland et al. 2009). Under PBC, voluntarism was an important contributor to the development of this legitimacy. Whilst practices have nominally 'volunteered' to join particular CCGs, this is against a background of being contractually required to do so. Our case studies suggest that this contractual requirement has made some developing CCGs somewhat cautious in developing systems to monitor and improve practice performance, although they retain an appetite to do so.

In terms of generating the engagement and interest of GP members, our case studies suggest that this is most easily achieved by focusing upon clinical topics of immediate interest to GPs. Attempts to engage members with aspects of governance were less successful.

Further research is required to explore the attitudes of those GPs who have not taken up leadership positions, and to follow the success of attempts to engage new GPs over time.

4.4 Structures and governance

Our data show that:

- Issues relating to structures and governance have dominated the agenda over the past nine months
- The size of Governing Bodies varies significantly, with no relationship between size of CCG and size of Governing Body
- The requirements for accountability and governance associated with being a statutory body are significant and demanding, and GPs have no experience of this. In order to demonstrate adequate governance, CCGs are putting in place complex, multi-layerd structures. As membership organisations, CCGs also have to demonstrate internal accountability to their members, and this adds a further layer of complexity
- GP leadership roles are demanding, and the GPs involved have had significant development needs. There is some evidence that this managerial training, alongside the focus upon structures and governance, has to some extent distracted GPs from their initial focus upon clinical issues of immediate concern to patients
- Membership of Governing Bodies in many CCGs has not yet been finalised with many, for example, not yet having a nurse or consultant member. In addition, the division of responsibility for operational and strategic decision making between the various organisational tiers has not been resolved in many sites.
- Many groups had already set up their structures by the time the official guidance relating to governance issues came out in February 2012. There was thus a need for many to adjust their structures to meet the new guidance.
- The authorisation process will entail aspirant CCGs developing clear plans on paper, with formal schemes of delegation and statements of the principles underpinning their operation, particularly in relation to conflicts of interest. Our case study sites recognise that there is also a longer term issue to be addressed to do with developing a governance culture in which probity and transparency become second nature
- Currently, CCG assurance-level bodies tend to be dominated by male GPs, and many are aware that this is a significant issue. Salaried GPs have some representation, and there is a general awareness that this will be important to develop further in the future.
- Key outstanding issues to be considered by developing CCGs include:
    - What is the relationship between the 'assurance' level and the 'operational' level, and are both groups clear as to their responsibilities?
    - What is the relationship between the 'assurance' level and the wider GP membership?

- Who is responsible for setting strategy?
- What is devolved to what level within the organisation, and who can make decisions about which issues?
- How much overlap in activity and responsibilities is there between the different organisational tiers?

Although clinically-led commissioning has a long history, this is the first time that GPs have had the leading role in the statutory body holding responsibility for the commissioning of health care in their area. Our case studies suggest that GPs involved are taking this new role very seriously indeed, and it is for this reason that the development of structures and governance has so completely dominated the agenda over the past nine months. A great deal of time and energy has been expended in discussions about Governing Body membership, with particular concern about those roles prescribed by legislation. Overall, the issue of who should be on the Governing Body and what the role of that Governing Body should be are closely tied together, and there remains a lack of clarity particularly over such issues as which organisational tier should be responsible for strategy and for operational activity.

There appear to be additional complexities relating to accountability in the new CCG structures. The new system is considerably more complex than that experienced by previous NHS statutory bodies in primary care, with a new accountability to members as well as accountability to the public, to the NHSCB and, eventually, to HWB as well. It is not yet clear where responsibility for leading areas of work will sit in the new structures, and how the different organisational tiers will relate to one another. Overall we found that:

- There is an aspiration that the GP practice membership will be involved in the setting of strategy in some sites, but it is unclear how this will operate in practice
- Most CCGs are intending to appoint senior managers to lead areas of work, but have stated that not all of these will have a place on the CCG Governing Body. It has not yet been possible to appoint to these positions, as CCGs currently remain as sub committees of the PCT. GPs in leadership positions will work alongside these managers, but will not usually be physically present for more than a few sessions a week.
- Some areas of work may be led from the CSS, and it is unclear as yet how 'strategic' or 'operational' this leadership will be.

Further research is required to explore how this complexity develops over time, and to explore the relationship between the different organisational tiers.

4.5 Internal and external relationships

Our data show that:

- The key **internal relationship** of CCGs is the relationship with member practices:
  - Some smaller CCGs are working hard to ensure that their organisations are 'owned' by their members, with the members setting the agenda and driving strategy as well as holding the Governing Body to account, although this is proving difficult
  - In larger CCGs we did not see this, with the relationship conceptualised in terms of the membership selecting the Governing Body to do this work for them
  - Communication with the membership is seen as important by all CCGs, but what this means is seen differently by different groups.
    - Some see communication as predominantly a one way process, focused upon 'informing' the membership
    - Some see communication as a limited two way process, with the emphasis upon both informing the membership and capturing 'usable intelligence' from the clinical front line

        - Some see communication as a full two way process, focused upon capturing the views of the membership to set the direction of the group as well as on keeping them informed
    - The role, purpose and remit of Locality groups remains unclear in all but one of our case study sites, and this finding is backed up by intelligence from the telephone interviews. This is particularly an issue in those groups which have merged. In particular, there is lack of clarity over the extent to which Locality groups should have responsibility for budgets and for commissioning decisions.
    - Case study CCGs and survey respondents regard the performance management of practice behaviour relating to commissioning such as referrals and prescribing is regarded as a legitimate role for CCGs, and this builds upon work that was already underway in all sites. There is evidence from some of the case studies that the move to CCGs has somewhat reduced the level of performance management being undertaken, in part due to lack of staff and in part due to a concern to avoid alienating CCG members. There is a potential tension between the desire to be a meaningful membership organisation and the need to manage performance. There is some concern over the lack of clarity surrounding the future management of the GMS contract and the role of CCGs in this.
- CCGs will have a number of important **external relationships**
- Amongst the most significant of these will be relationships with the **Local Authority**, including with the **Social Services** and with the **Health and Well Being Board**
    - Some case study sites report improved relationships with their LA since beginning their CCG journey, and are keen to develop even closer relationships by, for example, co-locating or sharing commissioning support staff. There has been some confusion as to whether or not this is permitted under the new system
    - There are still some uncertainties about how CCGs and H&WB will work together. In particular, there are concerns about:
        - The exact demarcation of responsibilities
        - Maintaining a local focus in those areas with a two tier LA
        - Different ways of working
        - The number of meetings GPs sitting on H&WB will be required to attend
        - The impact of politics, particularly if a Council changes hands
        - The lack of formal powers for either CCGs or H&WB to influence the work done by the other
    - Working across LA boundaries brings with it particular issues, but is felt to be justified by the advantages associated with working with prevailing patient flows
    - There are widespread concerns as to how Public Health will function in the new system
- The relationship with the developing **Commissioning Support Service** will also be very important.
    - The process of setting up CSS has been experienced as very disruptive by CCGs in many of the case study sites, with significant concerns about:
        - the size of the developing CSS
        - their ability to retain both trusted staff and a locality focus
        - the need to sign initial agreements with organisations which are not yet fully formed and whose capabilities they are not yet sure of
        - the loss of good staff and the significant uncertainty and anxiety for those staff remaining
    - Some of the problems have arisen due to a lack of specific guidance, with, for example, confusion over the rules relating to CSS/CCG agreements, in particular whether they are obliged to sign up with their local CSS or not
    - Some participants could see potential advantages to a large CSS, including economies of scale and the ability to share best practice, whereas others are more concerned that their support should have a local focus

- **Patient and public engagement** is something which all of our case study sites have expressed commitment to, with many telling us that they are aiming to engage patients/the public in as many aspects of their work as possible.
    - Most are building on existing PPI structures and processes, but would like to embed the concept more deeply in what they do.
    - They continue to wrestle with familiar PPI issues, such as who is a valid 'representative, and in which aspects of the commissioning process can PPI be most effective/have legitimacy
- Relationships with **PCT Clusters** and **SHA Clusters** have been significant through the development period, and have been key factors in determining how CCG development has occurred.
- In the future, the relationship with the **NHS Commissioning Board** will be very important. Participants in the survey, case studies and telephone interviews are all anxious to see how this relationship will develop over time
- A number of other external relationships are also important, in particular the interaction with **local providers**. Some external partners who had close relationships with PCTs (eg **Community Pharmacy** and **Allied Health Professionals**) have no statutory role in the new system. Some CCGs have set up advisory bodies to include some of these actors.
- Some CCGs are beginning to develop active collaborative relationships with **other CCGs**. Some of these involve formal job sharing arrangements and early approaches to joint commissioning. There is some uncertainty as to exactly which statutory functions can be shared.

CCGs are new organisations, working in a changing external landscape. They are aware of the importance of developing stable and functioning relationships with their key external partners, but have been hampered in this by the fact that many parts of the NHS are changing at the same time, and that the different elements of the system are developing at different speeds. In this unstable environment, key personal and interpersonal relationship assume a greater importance than they might do in more stable systems, and individuals in our study have shown a great deal of commitment to developing these relationships and to setting up systems that will work whatever the final shape assumed by local landscape. In addition, previous research suggests that local history and relationships are key determinants of the way in which new organisations are perceived and made sense of, and it is therefore likely that the exact nature of these new relationships will be locally context dependent (Pope, Robert et al. 2006).

The development of Commissioning Support Services, and the relationship between CCGs and their CSS, will be key factors in the ongoing development of clinical commissioning, and the disruption associated with their development has been one of the more difficult aspects of the process so far for CCGs. This has been experienced by both managers and GPs, and cannot simply be attributed to the understandable concerns of staff whose jobs may be at risk. The disruptive effects of organisational change on organisational effectiveness (Fulop et al 2002) and on individual's psychological wellbeing (Cortvriend 2004) are well known, and overcoming these effects will be an important determinant of what happens next.

CCGs are aware of the importance of engagement with patients and the public, and are committed to finding new ways of approaching this. However, the issues associated with developing effective PPI mechanisms are well known (Harrison and Mort 1998; Learmonth, Martin et al. 2009), and CCGs are still in the early stages of working to overcome these.

In terms of internal relationships, CCGs are not yet sure what it means to be a 'membership' organisation. In addition, the relationships between the various organisational tiers (in particular, relationships between Governing Body, Council of Members and Localities) need to be clarified.

Further research is required to follow the ongoing development of CCG external relationships. In particular: the interaction between CCGs and H&WB and the balance of power between the two; the progress in integrating with social care services; the development of CSS; and the role of other actors in the new system. In addition, further research is required to explore the developing meaning of being a 'membership organisation'.

4.6 Emerging CCG activities

Our data show that:

- Commissioning activities have been to some extent disrupted by the current reorganisation. In particular, PCT Clusters have lost some commissioning staff, and others have been diverted to work upon issues to do with CCG development. Staff have worked hard to try to minimise the impact on such key programmes as Quality, Innovation and Productivity (QIPP), but some respondents reported that there had been a degree of loss of focus due to the transition
- In the second survey three quarters of CCGs had already, or planned to, set up new services in the next 12 months and two fifths had changed or planned to change some providers of existing services, but most of these service changes have been small in scale, short term pilots or linked to local enhanced services or innovation funding and only small scale decommissioning had occurred if at all.
- Commissioning was taking place at all levels - the PCT cluster, CCG and / or localities where they existed. The level at which this occurred was dependent on history, local relationships and changes to CCG configuration, with some CCGs actively seeking to take over responsibility for commissioning functions, whilst others have been concentrating on organisational development,
- Many of the sites could point to instances of perceived 'added value' in both the commissioning and contracting processes due to having clinicians (most commonly GPs) involved.
- The GP contribution in contracting negotiations was often cited as an important indicator of CCG success to date.
- Difficulties in commissioning were seen where CCGs had recently merged. Some GPs involved found the time involved to be a problem. Overall, GPs are realising that their new role will mean shouldering greater responsibility and accountability for commissioning decisions
- In addition to working to improve services and save money via commissioning and contracting, our case study sites and survey respondents were acutely aware of the need to influence GP behaviour in the areas of referrals and prescribing, and most were setting up processes to do this. Most of these build upon what was already in place under PBC.

This current reorganisation is the first in which GPs have assumed responsibility for the greater proportion of the commissioning budget. Studies of previous initiatives in clinically-led commissioning have overwhelmingly shown that most impact has been on relatively small scale projects, often involving GPs providing additional services themselves, with limited attention to population level interventions or large scale organisational change (Glennerster 1994; Wyke, Mays et al. 1999; Coleman, Checkland et al. 2009). CCGs will have greater scope to make significant changes, but it is not yet clear whether or not they will be equipped to do this. Furthermore, this raises the issue of conflicts of interest. This is important, because it is possible that the absence of any other statutory body to 'hold the ring' with respect to conflicts of interest in commissioning decisions will inhibit GPs from developing innovative local services. Equally, it also suggests that it is more important than ever to avoid the appearance of significant conflicts of interest, as there is a risk that this may undermine public confidence in the NHS.

We found an emerging consensus amongst GPs and managers that GPs 'add value' to both commissioning and contracting discussions with providers. Although there is, as yet, no concrete evidence to back up this claim, our respondents believe that this is potentially one way in which the

new system may bring about genuine and significant change, in particular by changing the balance of power between Foundation Trusts and commissioners (Checkland, Harrison et al. 2009).

The extent to which CCGs are able to achieve change in GP referral and prescribing behaviour will depend upon the extent to which they are able to engage their members and achieve legitimacy for the project as a whole. Evidence from Fundholding suggests that this is a key way in which money may be saved. (Stewart-Brown, Surender et al. 1995; Surender, Bradlow et al. 1995; Rafferty, Wilson-Davis et al. 1997; Toth, Harvey et al. 1997). Some developing CCGs are very large, and it may be more difficult for these groups to manage this process.

Further research is required on the development of CCG commissioning and contracting processes, in particular the balance between work done by the CCG and that done by the CSS and the relationship between the two entities. In addition, further research is required to elucidate how far the perceived benefits of involving GPs in commissioning and contracting meetings are borne out in practice, and whether they outweigh the undoubted costs of this approach.

4.7 Strengths and limitations of the study

This study represents a snapshot of a changing process. Data was collected from September 2011-June 2012, with respondents asked to reflect on their experiences from the outset of their journey as Pathfinder CCGs. The data collected in this time were both wide and deep, so that we can be confident that the picture presented here is broadly representative of the experiences of the wider population of CCGs over this time. However, the rapidly developing context must be borne in mind in interpreting these findings, as issues which arose and were of significant concern at one point in time were often superseded or solved as new guidance emerged or the wider context changed. In order to provide evidence which is of ongoing value, we have therefore endeavoured to be as clear as possible in this report about the underlying longer term issues which particular incidents illustrate. Thus, for example, in the early stages of data collection, a perceived pressure to merge smaller CCGs was of great concern; by the end of the data collection, merged CCGs were beginning to settle down as functioning organisations. However, this process highlighted ongoing concerns and issues to do with: the extent to which ‘freedom’ to develop as CCGs chose was real; the way in which guidance was provided; the relationship between practices and their CCG; and the role of Locality groups in CCGs. We therefore feel that, whilst many of the events and issues described here are in the past, their exploration and analysis provides valuable information relevant to the future development of CCGs.

The rapid pace at which this project was conducted also carries with it drawbacks. In particular, we have not always had the space and time for reflection that we would have liked. Whilst we are confident in the quality of the initial analysis provided here, it is our intention to continue to subject the data that we have collected to further analysis, and to produce additional supplementary reports or academic papers which focus more deeply on particular findings.

The surveys that we carried out were descriptive in nature, and have not been subject to more complex statistical analysis. In the context of the volume of work facing CCGs at the time the surveys were carried out, response rates of 41% (December survey) and 56% (April/May survey) are good. However, we did not conduct a systematic analysis of non-responders, and so cannot make firm claims as to the representativeness of the responses we received. For this reason the survey data has been used to provide descriptive context rather than providing any more sophisticated analysis. The difficulties over obtaining contact details for the telephone interviews, and subsequent difficulties experienced in making appointments to talk to those selected meant that this aspect of our data has been less well explored than the other elements. We considered leaving this data out of the report altogether, but concluded that its inclusion (with appropriate caveats) provided additional valuable context for some issues. Further analysis of the interviews

following the initial submission of this report has confirmed that data saturation (Murphy et al 1998) had been reached, with no significant new themes occurring.

Finally, this report does not provide a detailed analysis of our findings in the context of the wider literature relating to clinical commissioning, although we have provided some limited reference to this wider literature in this discussion. Such an analysis (and consequent lessons for the future strategic direction of policy in this area) will be important and valuable, but is outside the scope of a report commissioned to provide early and actionable lessons for those charged with the ongoing operational management of CCG development. We will be publishing a literature review relating to clinically-led commissioning soon (Miller et al forthcoming), and are currently working to further develop the analysis of our data in the context of this.

5 Conclusions and lessons

The rapid pace of change and the short timescale over which the research has been conducted have been challenging, and this report therefore presents a picture of a changing landscape. However, the data collected are both detailed (in the case study sites) and broad (in the surveys) in scope; we are therefore confident that the findings presented here are relevant to the wider population of CCGs.

Our study has shown that the 'pathfinder' approach was a very effective way of generating momentum in the development of CCGs, with virtually the whole of England covered by an emerging CCG within six months of its announcement. Those who signed up in the early waves reported an initial sense that they were able to feed back their experiences to those responsible for the implementation of the policy. However, this was quickly lost as the number of emerging CCGs rapidly increased. Since the policy was introduced, a great deal of time consuming work has been undertaken by both GPs and managers involved in the development CCGs, much of it in their own time, and many of those involved in leadership positions have found the process to be personally rewarding. The picture as a whole remains one of flux, with ongoing change affecting:

- CCG organisational structures
- CSS development and their relationship with CCGs
- H&WB development and their relationship with CCGs
- The role of the NHS Commissioning Board and its approach to CCG management
- The interaction between CCGs and their member practices
- The development of the new public health service and associated structures

Our research shows that there is a significant ongoing commitment to the idea of GP-led commissioning. Some sites reported improved relationships with external organisations such as Local Authorities and local providers. There was also enthusiasm for local innovation and service redesign, and some evidence of an increasing sense of ownership of the contracting process. As yet we have seen little evidence of significant involvement of other clinicians, such as nurses and hospital doctors for whom a formal role has been centrally prescribed. In addition, some CCGs are concerned that other actors such as Community Pharmacists no longer have a formal role. There is a belief that GPs add value to the commissioning and contracting process. It is too early for evidence to confirm this belief to have emerged.

Overwhelmingly our respondents in case studies and telephone interviews told us that they were already strengthening the involvement of GPs in commissioning prior to the current changes. In fact CCGs are being built upon what had gone before, such as PBC Groups and, in some cases, Primary Care Groups. We were told repeatedly that respondents believed that the objective of developing clinical commissioning could have been achieved within existing structures, without the disruption associated with the current reorganisation of the NHS.

The most difficult aspect of the last nine months has been the fact that many aspects of the NHS (and some associated Local Authority structures) have been undergoing significant change at the same time. This has generated delays, disruption and confusion, as developing CCGs have wrestled with the associated uncertainties. Furthermore, it has contributed to a significant loss of experienced managerial personnel, and has tended to distract CCGs from the core business of commissioning, as they have had to focus on organisational and procedural development.

Clearly this study reports upon the very early stages of CCG development, up to the beginning of the authorisation process. Many of the issues highlighted here will continue to be pertinent in the ongoing development of the new commissioning architecture. It will be valuable to examine the

progress of CCGs leading up to and following authorisation and beyond. Indeed, our study sites were keen to continue participation in the research.

Lessons relevant to the further development of CCGs:
We draw the following lessons from our study:

- Implementation processes such as the Pathfinder approach, that aspire to actively engage front line staff in shaping the direction of travel, carry with them the risk of raising expectations that may not be met, resulting in disillusion for the staff involved. This risk may be mitigated by ensuring that there is clarity for all involved over which aspects of the programme are open to modification and which are the subject of higher level strategic decisions. In addition, ways need to be found to ensure that those who do engage at an early stage in providing active feedback continue to feel valued throughout the later stages of the process.

- CCGs would welcome greater clarity and timeliness of guidance. Whilst they do not want to be directed from above, they would like a clearer statement of what the eventual overall structure will look like, with clear guidance as to what is and is not 'allowed'. Within this clear structure they would like to be given the autonomy to innovate and develop their own local organisational responses.

- CCGs would also welcome greater clarity over the new role of the NHS Commissioning Board and its relationship with CCGs. In particular, some would like to have a clearer sense of how the primary care GMS (and PMS/APMS) contract will be managed, and their role in this.

- The NHS Commissioning Board should identify specific points of contact for local CCGs. Personal contacts are valued, and CCGs are keen to be able to get to know and work consistently with particular local NHS Commissioning Board personnel.

- Clarity is required urgently over the employment destinations of managerial/commissioning staff. Experienced and valued staff members are under great strain and some are leaving due to the uncertainty about their employment prospects.

- At a local level, the process of clarifying roles and responsibilities between CCGs and their CSS needs to be expedited.

- The NHS Commissioning Board could usefully encourage CCGs to pay attention to their membership, including the developing role of their Locality groups/Council of Members. In the longer term the ability of CCGs to change GP behaviour will depend upon their perceived legitimacy, which in turn depends upon the approach that they take to engaging members.

- CCGs need to consider: the degree of autonomy devolved to Localities; the role of the members in contributing to strategy development; approaches to quality improvement/performance management; and the extent to which the CCG may be a vehicle for the transfer of expertise and resources between practices.

- In order to develop a new generation of clinical leaders, NHS Commissioning Board resources could usefully be devoted to encouraging a model of incremental engagement that builds upon GPs' commitment to local clinical innovation. In addition, these aspirant leaders will require ongoing access to training and development support

- CCGs need to provide opportunities for aspirant leaders (including female GPs, non-principal GPs and other health care professionals) to become engaged in commissioning activities in an incremental way

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7 Appendices

Appendix 1: Full list of original and supplementary research questions

To describe in a sample of 'pathfinder' Clinical Commissioning Groups

- arrangements for integrating individual general practices into the wider organisation, clinical leadership, and any arrangements for the performance management of practices, arrangements made for consortium governance and decision making, including adherence to CCG decisions, especially in relation to demand management;
- Processes for the formulation of CCG priorities and commissioning strategies, including liaison or collaboration with other commissioners (eg any multi-consortia arrangements), collaboration with providers (eg over design of patient pathways), service relocations from secondary to primary care settings, and development of quality standards for inclusion in contracts;
- Provision and funding of external clinical support (eg pharmacy), management and administrative support arrangements, together with approaches to financial management, internal monitoring of expenditure, the pursuit of efficiency and productivity, and reported administrative costs of CCGs; and
- Arrangements for wider engagement, including any contact with regulatory agencies, participation by public and/ or patient groups (including any developed by CCGs), involvement of local government authorities (including shadow Health and Well Being Boards, health scrutiny), and public health staff, clinical senates and any social marketing of CCG, their priorities and achievements to the general public. A particular focus here will be on the processes by which commissioning plans are considered and passed (or not) by the other stakeholders such as Health and Well Being Boards, clinical senates etc.

2. To obtain for the wider population of 'pathfinder' CCG extant at 1 September 2011 baseline data on:

- CCG size, in terms of numbers of practices, GP principals, registered patients, and budget allocation (if this latter information is available);
- CCG governance arrangements, including relationships with and performance management of constituent practices and individual clinicians, recruiting lay members and a secondary care specialist to the CCG, relations with new clinical senates and public/patient involvement;
- Sources and costs of commissioning support and administration more generally;
- Services commissioned by CCGs at the time of data collection and stated future commissioning intentions and priorities;
- Strategies adopted for commissioning providers and forms of contract employed;
- Arrangements for external relations, including local government authorities, clinical senates, PCT and SHA clusters and secondary care clinicians; and
- Arrangements for the monitoring and performance management of providers.

3. To assess, within the limitations of the study timescale:

- CCG achievements in terms of creating a functioning cohesive organisation with governance arrangements that are perceived by GP / lay / other members as appropriate and legitimate; and
- Any early CCG achievements in terms of commissioning novel, more effective, more efficient and/ or more accessible services and/or decommissioning existing services.
- The local and national (eg further changes in legislation) factors that appear to have affected these achievements

It was subsequently agreed with the Department of Health that, in addition, the research would seek to answer some of the following questions which were of interest to those responsible for facilitating the development of Clinical Commissioning Groups:

1. What are the key factors which the NHS Commissioning Board will need to address in the support it provides to clinical commissioning groups (CCGs) during 2012/13 to ensure their readiness to assume responsibility for commissioning?
   For example:
   - What types of support have pathfinders found most and least helpful to date?
   - What additional support would have been / be helpful?
   - What do CCGs see as the key factors the NHS CB will need to address in terms of support for CCGs in 2012/13?

2. How has emerging CCG development and pathfinder agreement been undertaken locally?

3. How are pathfinders considering how to best commission services at different geographical levels and how to commission some of the more specialised and complex local services such as mental health, maternity and children's services? What is the emerging evidence about the relative benefits of different approaches?

4. How have pathfinders have gone about establishing themselves to ensure that they can be properly accountable for all their functions?

5. How are they planning to put in place robust management arrangements to enable them to work collaboratively with other organisations and what processes have been undertaken to determine whether emerging CCGs undertake the functions for themselves, collaborate or buy in from third party organisations?

6. Over the past year, how (and how successfully) have pathfinders gone about:
   - Planning services (e.g. is the CCG fully engaged with local needs assessment and strategic planning, and is it reflected in their commissioning?)
   - Agreeing services (e.g. how effective is CCG planning and contracting?)
   - Monitoring (e.g. are CCGs developing plans/systems that will enable them to secure continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience?)
   - Improving the quality of primary care (e.g. are CCGs developing systematic ways of driving up quality of general practice?)
   - Finance (e.g. are CCGs developing effective plans for managing financial resources and financial risk, and which allow the necessary transformational changes to deliver QIPP?)
   - Governance (e.g. are CCGs developing effective systems to make decisions, involve practices, manage conflicts of interest?)
   - Specific duties of co-operation (e.g. are CCGs developing effective relationships with patients and the public, local authorities and other health/care professionals? What is the process and outcomes for managing relationships within CCGs, across the health and social care system (specifically Local Authorities, Secondary Care and Community Care) and with the NHS Commissioning Board?)

7. What other approaches are pathfinders developing to the full range of their duties and functions as set out in the Health and Social Care Bill, and the Functions document and what are the relative merits of these?

8. What early insight is there into where clinical commissioning can enhance value for money?

Exploring the early workings and impact of Pathfinder Clinical

This survey is part of a research study on Pathfinder (or emerging) Clinical Commissioning Groups (referred to in this survey as CCGs) being conducted by the Department of Health-funded Policy Research Unit in Commissioning and the Healthcare System (PRUComm). The Department of Health have asked PRUComm to undertake this survey among all Pathfinder CCGs in waves 1 to 5. The aim of the Pathfinder Programme is to allow lessons to be learnt as emerging CCGs start to take up the challenges ahead. This research is part of that learning process. When applying for Pathfinder status, CCGs were made aware that they would be involved in a research programme. This project has been subjected to independent peer-review, and has NHS Ethics approval.

Information derived from this survey will be aggregated and used for study reports, conference presentations and articles in academic journals. The study report will be submitted to the Department of Health, and will be available to participating organisations. Findings will be reported anonymously, without identifying individual people or CCGs, and treated as completely confidential within the research team. No information that can identify you or your CCG will be passed to the Department of Health or NHS.

Further details about this study and PRUComm can be found on our website: www.prucomm.ac.uk

Many thanks in anticipation of your help

Stephen Peckham BSc. MA(Econ), HMFPH
Director, PRUComm.

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Your Pathfinder CCG

This first section asks for background information about your Pathfinder Clinical Commissioning Group. This will enable us to analyse later questions in relation to the some of the base information about your CCG.

1. What is the population size of your CCG? (Please state number with no spaces or commas)

2. How many practices are members of your CCG?

3. How many GPs are there in total in your CCG?

4. How many Shadow Health and Wellbeing Boards does your CCG relate to?

- ◯ ONE
- ◯ TWO
- ◯ THREE OR MORE

5. Were any of the practices in your CCG previously part of a primary care commissioning organisation such as a practice based commissioning group, Total Purchasing Pilot, GP Fundholding multi-fund?

- ◯ YES
- ◯ NO

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6. We are interested in how the current group relates to previous types of commissioning group in your area. Were the constituent practices of the CCG previously part of or a whole? (please tick all that apply)

	All the same practices	More than Half	Less than half	None
Practice based Commissioning group(s)	◯	◯	◯	◯
Primary Care Group	◯	◯	◯	◯
GP Commissioning Group	◯	◯	◯	◯
Total Purchasing Pilot	◯	◯	◯	◯
GPFundholding Multi-Fund	◯	◯	◯	◯
Locality group	◯	◯	◯	◯
Other (Please specify)	◯	◯	◯	◯

Comments

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7. Has your CCG changed in membership from the group that applied to be a pathfinder?

- ◯ YES
- ◯ NO

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8. Please tick the statement that best indicates the change that has occurred

- ◯ Two or more pathfinders merged to form a new CCG
- ◯ Pathfinder split apart to form more than one CCG
- ◯ Pathfinder has become part of a federation of CCGs
- ◯ One or more practices has joined the CCG
- ◯ Other (please give details)

Details or other comments

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Section Two: Governance arrangements

In this section we would like you to tell us what the arrangements are for key decision making processes within the Pathfinder CCG and how you engage with the constituent practices of the CCG and other key stakeholders. We would like to know the composition of the CCG's key decision-making committee and other governance/membership arrangements.

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9. All CCGs have a key decision-making committee that takes corporate responsibility for the activities of the CCG (this may be called an executive board, cabinet, management board etc) but is identified as the place where corporate responsibility of the activities of the CCG is located. Currently, how many members are there for this committee in your CCG? (Please type in the number in the box below)

10. Please list the roles (chair, medical director, lay member etc) and disciplinary background (doctor, nurse, manager etc) of each member of the key decision-mking committee. Please select from drop down menus. If you have indicated other please give details below and identify which board member you are referring to (eg 1, 2, 3 etc).

	Role	Discipline
First committee member		
Second		
Third		
Fourth		
Fifth		
Sixth		
Seventh		
Eighth		
Ninth		
Tenth		
Eleventh		
Twelfth		
Thirteenth		
Fourteenth		
Fifteenth		
Sixteenth		
Seventeenth		
Eighteenth		
Nineteenth		
Twentieth		

If other selected above please give details.

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11. How were members of the key decision-making committee described in the previous question selected? Please tick the statement that best describes the method used in your CCG and add any comments that may help explain the method more fully.

- ◯ Elected by practices (eg one vote per practice)
- ◯ Elected by all member GPs
- ◯ Appointed/selected by PCT
- ◯ Appointed/selected by lead GPs in CCG
- ◯ Other (please describe below)

Details

12. How often does this group meet? Please tickone answer only.

- ◯ Weekly
- ◯ Fortnightly
- ◯ Monthly
- ◯ Bi-monthly
- ◯ Other (please specifiy below)

Details

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13. How does the CCG engage with or report to its members? Please tick yes or no to each method and provide details of other methods used by your CCG.

	YES	NO
Locality meetings of practices	☐	☐
All member meetings	☐	☐
Newsletter or email communication	☐	☐
Other (please specify)	☐	☐

Comments

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Section Three: Pathfinder status

This section asks about your experience as a Pathfinder. We are interested in why groups became Pathfinder CCGs and what impact being a Pathfinder CCG has had on the activities of your CCG.

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14. When was the CCG first formed?

DD MM YYYY

Date ☐ / ☐ / ☐

15. When did you apply for Pathfinder CCG status? Please give month and year.

DD MM YYYY

Date ☐ / ☐ / ☐

16. What were the three main reasons for applying for Pathfinder CCG status? Please write one reason in each of the boxes below.

1. ☐
2. ☐
3. ☐

17. How beneficial to the CCG has membership of the Pathfinder programme been? Please indicate for each level (local, regional and national) or tick no support if none received at any level.

	Local support or events	Regional support or events	Nationally support or events
Very beneficial	☐	☐	☐
Fairly beneficial	☐	☐	☐
Neither beneficial nor not beneficial	☐	☐	☐
Not very beneficial	☐	☐	☐
Not beneficial at all	☐	☐	☐
No support received	☐	☐	☐

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18. If very beneficial or fairly beneficial please identify up to three benefits from seeking Pathfinder CCG status. Please write one benefit in each of the boxes below.

1.

2.

3.

19. Who made the decision to form the Pathfinder CCG? Please tick one answer.

- ◯ Existing group (eg PBC, locality group) (please give details below)
- ◯ Led by GPs who recruited other member practices
- ◯ Formed by PCT
- ◯ New coalition of practices formed specifically for the Pathfinder CCG
- ◯ Other (Please give details below)

Details

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Section Four: Management and organisational development

In this next section we are asking about what management and development support the CCG has had and who provided/provides it. We are also asking about how specific functions have been organised in the CCG.

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20. Since becoming a CCG what management and leadership training have key personnel received? (Please tick all that apply)

	From PCT/cluster	SHA	Social enterprise (ex NHS)	Private company/consultancy	Local higher Education/Deanery	LMC	Other (please specify)
Leadership training	☐	☐	☐	☐	☐	☐	☐
Organisational development	☐	☐	☐	☐	☐	☐	☐
Governance and assurance	☐	☐	☐	☐	☐	☐	☐
Communication / engagement	☐	☐	☐	☐	☐	☐	☐
Public Health	☐	☐	☐	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐	☐	☐	☐

21. Where does your CCG currently obtain its support for the following functions? (Please tick all that apply)

	From PCT/cluster	Existing Practice-based-Commissioning staff	From constituent practices	Private company/consultancy	Social enterprise (ex NHS)	Other (please specify)
General administrative and management support	☐	☐	☐	☐	☐	☐
Commissioning	☐	☐	☐	☐	☐	☐
Finance	☐	☐	☐	☐	☐	☐
Medicines management	☐	☐	☐	☐	☐	☐
Public and Patient Involvement/ engagement	☐	☐	☐	☐	☐	☐
Human resources	☐	☐	☐	☐	☐	☐
Governance and assurance	☐	☐	☐	☐	☐	☐
Organisational development	☐	☐	☐	☐	☐	☐
Other (please specify)	☐	☐	☐	☐	☐	☐

Other (please specify)

Exploring the early workings and impact of Pathfinder Clinical

22. Does your CCG have a patient and public engagement strategy?

- ◯ YES
- ◯ NO
- ◯ Don't know

Please give details

Exploring the early workings and impact of Pathfinder Clinical

23. If your CCG has a patient and public engagement strategy is this a document that is available publicly?

- ◯ YES
- ◯ NO
- ◯ Don't know

Please give details

24. Does your CCG have a lead person for patient and public engagement?

- ◯ YES
- ◯ NO

If yes please give details:

25. How many of the CCG member practices have a patient reference group? Please give the number of practices or write Don't Know.

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Section Five: Activities and priorities of the CCG

This section is asking for brief details about the original and future priorities for the CCG.

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26. What were the three main motives/key objectives of the founding/ on forming the CCG? Please write one objective in each box below.

1.
2.
3.

27. What are the CCGs top three priorities over the next six months? Please write one objective in each box below.

1.
2.
3.

28. What are the the CCGs top three priorities to be achieved before April 2013? Please write one objective in each box below.

1.
2.
3.

29. What are the CCGs top three priorities to be achieved in the next three years?

1.
2.
3.

Exploring the early workings and impact of Pathfinder Clinical

Section Six : Person completing questionnaire

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30. What is your role or job title?

31. When did you become involved in the CCG?

- ◯ Since September 2011
- ◯ Between April and August 2011
- ◯ Between January and March 2011
- ◯ Before 2011

32. What is your disciplinary background?

- ◯ GP
- ◯ Nurse
- ◯ Other clinician (give details)
- ◯ Practice manager
- ◯ PCT manager
- ◯ Manager from NHS provider organisation
- ◯ Manager previously employed outside the NHS
- ◯ Other (give details)

Please give details if you selected 'other clinician' or 'other'.

Second Survey of Pathfinder Clinical Commissioning Groups

This is the second survey of Pathfinder (or emerging) Clinical Commissioning Groups (CCGs). This survey is part of the research study on Pathfinder CCGs being conducted by the Policy Research Unit in Commissioning and the Healthcare System (PRUComm) funded by the Department of Health.

The Department of Health have asked PRUComm to conduct a series of surveys among all wave 1 to 5 Pathfinder CCGs. The aim of the Pathfinder Programme is to allow lessons to be learnt as emerging CCGs start to take up the challenges ahead. This research is part of that learning process. When applying for Pathfinder status, CCGs were made aware that they would be involved in a research programme. This project has been subjected to independent peer review, and has NHS Ethics approval.

Information derived from this survey will be aggregated and used for study reports, conference presentations and articles in academic journals. The study report will be submitted to the Department of Health, and will be available to participating organisations. Findings will be reported anonymously, without identifying individual people or CCGs, and treated as completely confidential within the research team. No information that can identify you or your CCG will be passed to the Department of Health or NHS.

Further details about this study and PRUComm can be found on our website: www.prucomm.ac.uk

As this is the second survey following the one conducted in December 2011, we felt it was necessary to repeat a small number of background questions about your CCG in order to ascertain the scale of any changes. Please answer all the questions even if you provided some of this information before.

As we endeavour to gain an insight into a whole range of challenges and opportunities that CCGs face, it is extremely important for us to obtain information about all CCGs. We would be grateful if you could take part in this survey now.

We recognise that CCGs do not yet exist as they have not been authorised. However for the brevity in the rest of the survey we use the term 'CCG' to refer to your current emerging CCG.

Many thanks in anticipation of your help.

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Director, PRUComm.

Second Survey of Pathfinder Clinical Commissioning Groups

Section One: Your Pathfinder CCG

The aim of this section is to gather some background data about your CCG and to track any changes that affected your CCG since the application for pathfinder status.

1. What is the population size of your CCG? (Please state number with no spaces or commas)

Size

2. How many practices are members of your CCG?

Number of practices

3. How many Shadow Health and Wellbeing Boards does your CCG relate to?

- ◯ One
- ◯ Two
- ◯ Three or more

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4. We are interested in how many Acute Trusts (i.e. main hospitals, excluding mental health trusts) you have significant relationships with. Do GPs in your CCG largely refer to

- ◯ A single acute trust
- ◯ Two acute trusts
- ◯ More than two acute trusts?

5. Is the body applying for authorisation the same or different (as far as GP practice membership is concerned) to the one which applied for a pathfinder status?

- ◯ The same
- ◯ Different
- ◯ Difficult to predict, changes may occur between now and authorisation

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6. Please tick the statement that best indicates the change that has occurred

- ◯ Two or more pathfinders merged to form a new CCG
- ◯ Pathfinder split apart to form more than one CCG
- ◯ One or more GP practices has joined the CCG
- ◯ One or more GP practices has left the CCG
- ◯ Other (please give details)

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7. Does your CCG have a publically available website?

- ◯ Yes
- ◯ No
- ◯ Under construction
- ◯ Don't know

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8. Please provide the link in the box below

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Section Two: Governance arrangements

In this section we would like you to tell us the composition of the CCG's corporate decision making body.

9. All CCGs will have a key decision making body that takes corporate responsibility for the activities of the CCG.

We realise that the membership of this corporate decision making body will be subject to formal appointment processes as you proceed to authorisation. However we are interested in who is fulfilling the roles at the present time.

Currently, how many members are there for this corporate decision making body in your CCG? (Please type in the number in the box below)

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10. Please list the disciplinary backgrounds of the corporate decision making body members. Please select all that apply and indicate the number of MALE and FEMALE members with a particular disciplinary background.

Please note that the numbers should add up to [Q9], the total number of members of the corporate decision making body.
If a person has more than one disciplinary background, please select the main or primary one prioritising clinical backgrounds over managerial ones.
If you have indicated 'other' disciplinary background please give details below.

	Disciplinary background represented?	No. of MALE members of this disciplinary background	No. of FEMALE members of this disciplinary background
GP partner			
GP salaried			
Secondary care specialist			
Other doctor			
Practice nurse			
Community nurse			
Nurse specialist			
Other Nurse			
Health visitor			
Public health specialist			
Allied health professional			
Pharmacist			
PCT/ex PCT manager			
PCT/ex PCT Non Executive Director			
Practice manager			
Hospital manager			
non NHS manager			
Councillor			
Social services manager / officer			
LINKs member			

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Member of public			
Other (please specify)			

Other (please specify)

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11. Moving forward, you will be thinking about the specified roles on the governing body that you will need to have in place.

Have you nominated anyone yet into the national assessment centre and development process who is interested in the position of Chair of governing body? If yes, please indicate their disciplinary background.

	Nominated?	Disciplinary background
Chair of governing body		

12. Have you nominated anyone yet into the national assessment centre and development process who is interested in the position of Accountable Officer? If yes, please indicate their disciplinary background.

	Nominated?	Disciplinary background
Accountable Officer		

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13. Does your CCG have geographical localities within it?

- ◯ Yes
- ◯ No

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14. How many localities does your CCG have? (Please type in the number in the box below)

15. Does your CCG have the role of clinical locality leads/ directors / chairs within the decision-making body?

- ◯ Yes
- ◯ No

16. Are these roles occupied by GPs?

- ◯ Yes
- ◯ No

Comments

Second Survey of Pathfinder Clinical Commissioning Groups

Section Three: CCG's staff and functions

This section asks a number of questions regarding personnel and activities of your CCG.

17. Does your CCG intend to employ personnel directly in your CCG after achieving authorisation?

- ◯ Yes
- ◯ No
- ◯ Still undecided
- ◯ Don't know

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18. Whom do you intend to employ directly in the CCG? Please select the functions of the personnel and indicate the number of posts in each area.

	Intend to employ personnel?	No. of posts
Senior/Strategic management		
Governance and assurance		
Organisational development		
Medicines management		
Health needs assessment (developing JSNA, etc.)		
Business intelligence (data collection and analysis)		
Support for clinical pathways redesign		
Communications and Public and Patient Engagement		
Procurement and market management (agreeing contracts)		
Provider management (monitoring contracts, quality assurance, performance management)		
Human Resources		
IT		
Legal services		
Finance		
Estates		
General administrative and management support		
Public Health (non LA)		
Other function or activity (please give details)		

Other (please give details)

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19. Does your CCG intend to share any posts/employees with other organisations (e.g. LAs or other CCGs) after achieving authorisation?

- ◯ Yes
- ◯ No
- ◯ Still undecided
- ◯ Don't know

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20. Please write in the posts that your CCG intends to share and indicate the organisation (e.g. Local Authority, other CCG).

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21. Does your CCG intend to buy in any activities or functions (such as back office support e.g. IT or HR or any other aspects of commissioning support) from other organisations or companies after achieving authorisation?

- ◯ Yes
- ◯ No
- ◯ Still undecided
- ◯ Don't know

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22. Please indicate which functions and activities your CCG intends to buy in and from whom. Please select all that apply and indicate organisation or company.

If you have indicated 'other' function or 'other' organisation please give details in the box below.

	Intend to buy in?	Organisation
Senior/Strategic management		
Governance and assurance		
Organisational development		
Medicines management		
Health needs assessment (developing JSNA, etc.)		
Business intelligence (data collection and analysis)		
Support for clinical pathways redesign		
Communications and Public and Patient Engagement		
Procurement and market management (agreeing contracts)		
Provider management (monitoring contracts, quality assurance, performance management)		
Human Resources		
IT		
Legal services		
Finance		
Estates		
General administrative and management support		
Public Health		
Other function or activity (please give details)		

Other (please give details)

Second Survey of Pathfinder Clinical Commissioning Groups

Section Four: Commissioning intentions

This section asks you about your current and future commissioning intentions.

23. Please list your CCG's top three priority clinical areas for the next year. Please write in.

Clinical priority 1	
Clinical priority 2	
Clinical priority 3	

Second Survey of Pathfinder Clinical Commissioning Groups

24. Since becoming pathfinder has your CCG set up or does it plan to set up any new services in the next year?

- ◯ Yes
- ◯ No
- ◯ Don't know

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25. List up to three new services ...

Service 1	
Service 2	
Service 3	

26. ... and specify the procedure for choosing the provider

	Procedure for choosing the provider
Service 1	
Service 2	
Service 3	

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27. Since becoming pathfinder has your CCG changed or does it plan to change the provider of any existing services in the next year?

- ◯ Yes
- ◯ No
- ◯ Don't know

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28. List up to three services involving a change of the provider ...

Service 1

Service 2

Service 3

29. ... and specify the original provider and the procedure for choosing the new provider.

	Original provider	Procedure for choosing the new provider
Service 1		
Service 2		
Service 3		

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30. Since becoming pathfinder has your CCG redesigned or does it plan to redesign any existing services without changing their provider in the next year?

- ◯ Yes
- ◯ No
- ◯ Don't know

Second Survey of Pathfinder Clinical Commissioning Groups

31. List up to three services involving redesign ...

Service 1

Service 2

Service 3

32. ... specify their provider ...

	Provider
Service 1	
Service 2	
Service 3	

33. ... and specify the details of the proposed changes

Service 1 Redesign details

Service 2 Redesign details

Service 3 Redesign details

Second Survey of Pathfinder Clinical Commissioning Groups

34. Since becoming pathfinder has your CCG decommissioned or does it plan to decommission any existing services in the next year?

- ◯ Yes
- ◯ No
- ◯ Don't know

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35. List up to three services which have been or are being decommissioned ...

Service 1

Service 2

Service 3

36. ... specify the original provider ...

	Original provider
Service 1	
Service 2	
Service 3	

37. ... and specify the reasons for decommissioning the service

Service 1 Reasons for decommissioning

Service 2 Reasons for decommissioning

Service 3 Reasons for decommissioning

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38. Currently, do any of the CCG members who are GPs or Practice Managers attend contract negotiation meetings with existing or prospective providers?

- ◯ Yes
- ◯ No
- ◯ Don't know

39. Currently, do any of the CCG members who are GPs or Practice Managers attend contract monitoring meetings with existing providers?

- ◯ Yes
- ◯ No
- ◯ Don't know

Second Survey of Pathfinder Clinical Commissioning Groups

Section Five: Improving the quality of primary care

This section asks about any activities aiming to improve the quality of primary care.

40. Has your CCG taken any actions to improve the quality of primary care?

- ◯ Yes
- ◯ No
- ◯ Don't know

Second Survey of Pathfinder Clinical Commissioning Groups

41. What areas of primary care activity have quality improvement actions been focused on? (Tick all that apply)

- [ ] Referrals to secondary care
- [ ] Prescribing
- [ ] QOF scores
- [ ] Availability of appointments
- [ ] Adherence to devolved budgets
- [ ] Patient experience
- [ ] Other (please specify)

42. What quality improvement activities does your CCG undertake with constituent practices? (Tick all that apply)

- [ ] Sharing budgetary or other performance data in meetings
- [ ] Distributing comparative budgetary or other performance data to practices
- [ ] Visits to practices to discuss budgetary or other performance
- [ ] Incentives based on budgetary or other performance
- [ ] Other (please specify)

Second Survey of Pathfinder Clinical Commissioning Groups

Section Six: Participation in the Pathfinder Programme

In the penultimate section we ask you about your experiences of being a pathfinder CCG.

43. Overall, how beneficial was being a pathfinder for development of your CCG?

- ◯ Very beneficial
- ◯ Somewhat beneficial
- ◯ Neither beneficial nor not beneficial
- ◯ Not very beneficial
- ◯ Not beneficial at all

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44. Thinking about the time since becoming a pathfinder, please indicate three things associated with being a pathfinder that you have found particularly helpful in the development of your CCG.

Helpful 1.

Helpful 2.

Helpful 3.

45. Thinking about the time since becoming a pathfinder, please indicate three things associated with being a pathfinder that you found particularly unhelpful in the development of your CCG.

Unhelpful 1.

Unhelpful 2.

Unhelpful 3.

46. What support would you have liked to have been available as part of the Pathfinder Programme?

47. What support would you like from the NHS Commissioning Board in the future?

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Section Six : Person completing questionnaire

48. What is your role or job title?

49. When did you become involved in the CCG?

- ◯ Since September 2011
- ◯ Between April and August 2011
- ◯ Between January and March 2011
- ◯ Before 2011

50. What is your disciplinary background?

- ◯ GP
- ◯ Nurse
- ◯ Other clinician (give details)
- ◯ Practice manager
- ◯ PCT manager
- ◯ Manager from NHS provider organisation
- ◯ Manager previously employed outside the NHS
- ◯ Other (give details)

Please give details if you selected 'other clinician' or 'other'.

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Thank you for completing the survey.

Appendix 4

Telephone Interview Schedule

Could you introduce yourself and explain what is your role in the CCG.

Impact of organisational history

What history of working together do members of your CCG have?

How far does the current configuration of the CCG map onto previous administrative or commissioning groupings such as PBC group, Primary Care Group, GP Commissioning Group, Total Purchasing Pilot, GP Fundholding Multi-Fund, Locality group etc.?

Of the leading GPs in the CCG how many have been involved as GP leaders in the past?

In which groupings?

What type of previous grouping is being reproduced the most in your CCG (e.g. PCG, PBC) or is this a completely new type of grouping?

What are the perceived benefits of this?

What are the drawbacks?

How does it affect your way of working now?

Role of localities (if applicable) *(if available, interviewer to consult response to the second questionnaire*)

You have indicated that you have X geographical localities within your CCG. // (*If no prior data available*) Does your CCG have geographical localities within it? *(If no, move to the next section)*
How many?

What are their roles?

How much autonomy do they have?

Can they make commissioning decisions?

Do they have devolved budgets?

Are they responsible for particular clinical areas or administrative functions?

What representation do they have on the decision-making body of your CCG?

Leadership and governance *(if available, interviewer to consult response to the second questionnaire*)

What was the process for identifying the leaders of your CCG?

How were the persons who are being put forward for the key roles within your CCG such as the Chair, Accountable Officer and Chief Finance Officer identified?

What are their disciplinary backgrounds/ previous jobs/roles?

What is your view of the Governing Body Arrangements guidance in this respect?

How many leading GPs in your CCG are women? (e.g. 'leading' meaning those who are members of the decision making body)

What is your view about the gender balance on the decision-making body of your CCG?

Experiences of key milestones on a journey to authorisation

We would like to find out more specifically about your experiences of key milestones on a journey towards authorisation.

What are your views of the SHA's risk assessment process?

What are your views of the Commissioning Support Service guidance?

Added value of GPs

As far as commissioning is concerned, what do you think the added value of GPs is?

In what areas?

Experiences of the Pathfinder Programme *(if available, interviewer to consult response to the second questionnaire*)

We would like to find out more about your overall experiences of the Pathfinder programme.

You've indicated that you found X, Y, Z particularly helpful in the development of your CCG. Why these were helpful? How much difference did they make?

You've indicated that you found X, Y, Z particularly unhelpful in the development of your CCG. Why these were unhelpful? How much of a hindrance have they been?

// (*if no prior data available*) Thinking about the time since acquiring pathfinder status, which things associated with being a pathfinder that you have found particularly helpful in the development of your CCG. Why these were helpful? How much difference did they make?

Thinking about the time since acquiring pathfinder status, which things associated with being a pathfinder that you have found particularly unhelpful in the development of your CCG. Why these were unhelpful? How much of a hindrance have they been?

What support would you have liked to have been available as part of the Pathfinder programme?

What support would you like from the NHS Commissioning Board in the future?

How would you rate your overall experience of being a pathfinder CCG so far?